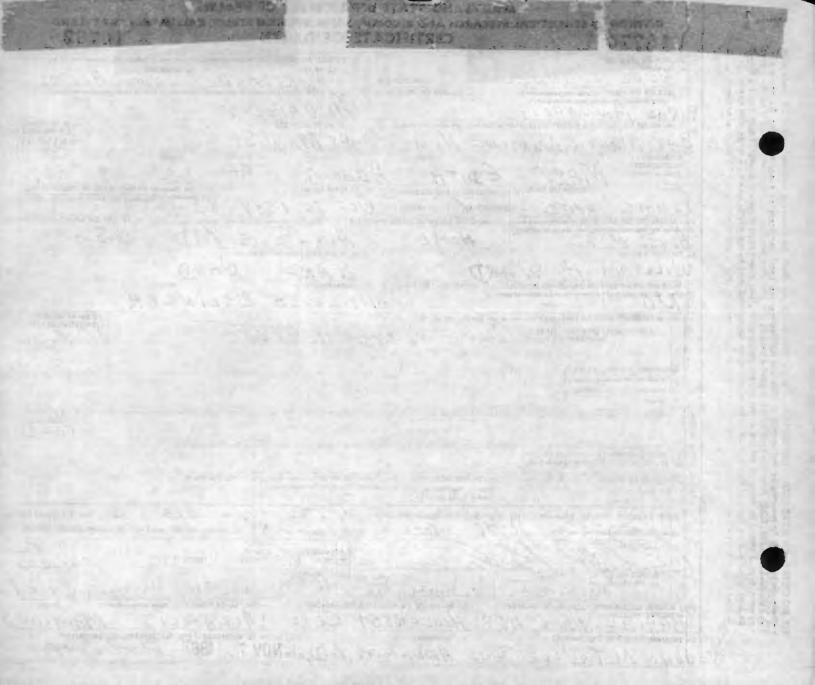
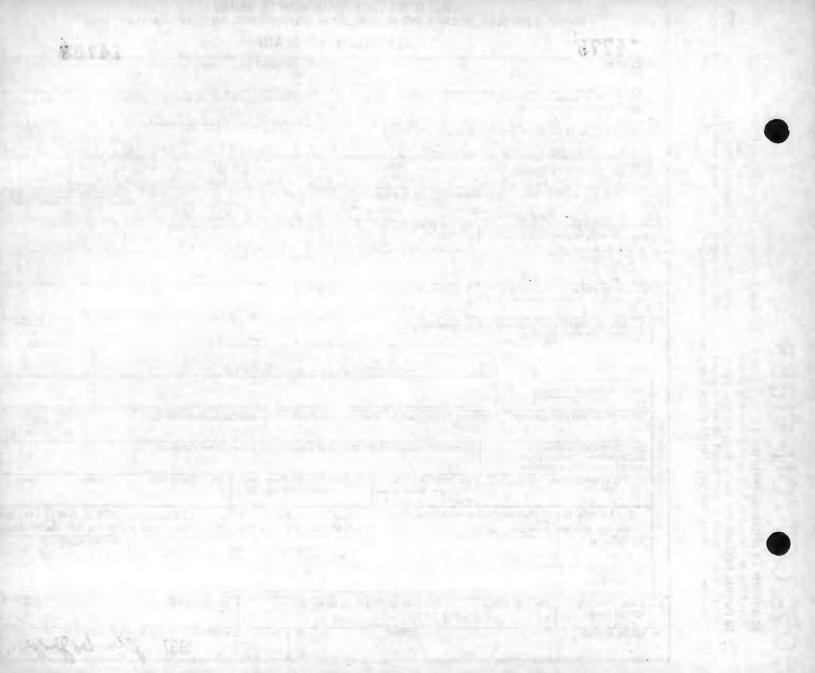
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 201 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before edmission) MARYLAND b. CITY OR TOWN (if outside corporele limits. c. LENGTH OF STAY IN 16 OR TOWN IIf outside corporate limits, write RURAL and give nearest fown) write RURAL and give nearest town INSTITUTION lift not in hospital, give street address) . IS RESIDENCE ON A FARM? YES NO E Dey Year DECEASED (Type or print) DEATH 1967 COLOR OR RACE 7. MARRIED 5. SEX 9. AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS. NEVER MARRIED dest birthday) Months USUAL OCCUPATION (Give kind of work done, during most of working life, even if retired) HOME. 13. FATHER'S NAME WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. | 17. INFORMAN Address (Yes, no, or unkown) | (If yes give wer or dates of service) SLING-ER 18. CAUSE OF DEATH [Enter only one cause per line log to). (b), and (c). INTERVAL BETWEEN ONSER AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which (61 gave rise to immadiate cause DUE TO (a), stating the underlying cause last. PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? I NO F 200. ACCIDENT WAS UNDERLYING [] 20b. DESCRIBE HOW INJURY OCCURED, (Enter natura of injury in Part I or Part II of itam 18.) OR CONTRIBUTING CAUSE OF DEATH MEDICAL 20c. TIME OF INJURY 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Homa, farm, 20f. (City or fown) (County) (State) Month, Day, Year fectory, straat, offica bldg., atc.) While Not While Hour e.m. ef work at work 26 19 67, and that death occurred at 30 M, from the causes and on the date stated above. 220. SIGNATURE DATE ATTENDING. SIGNED PHYS. DIRECTOR PHYS. M.D. FUNERA 22c. PHYSICIAN' 22d. ADDRESS director, Filed 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) 23s, BURIAL, CREMATION, 23b. 24 FUNERAL DIRECTOR'S SIGNATURE VR A15 (41-



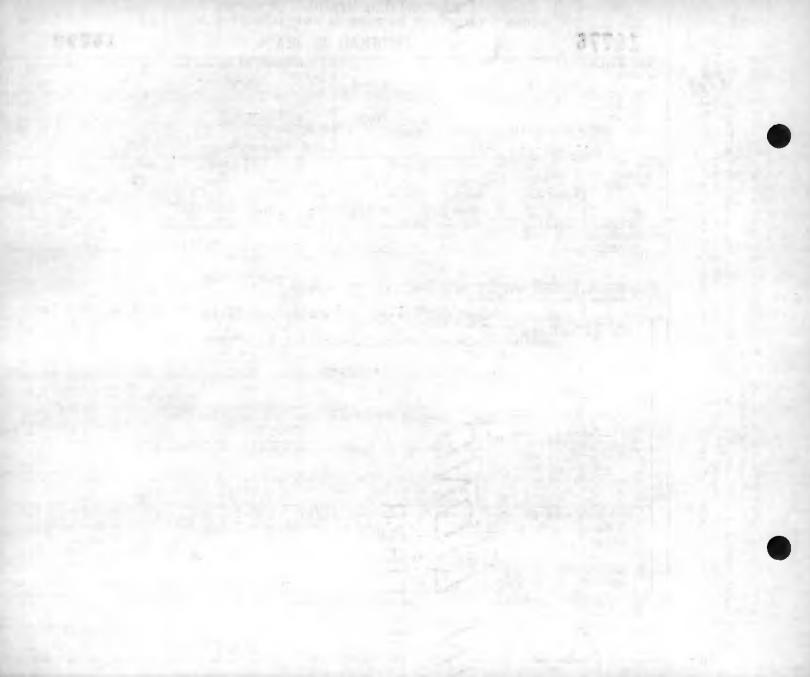
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 14775 funeral 1 and 2 death requires that the death certificate be executed within 24 hours after death 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH o. STATE a. COUNTY b. COUNTY MARYLAND c. CITY OR TOWN (If gutside corporate limits, write RURAL and give negrest town) b. CITY OR TOWN (If autside corporate limits, C. LENGTH OF STAY IN 16 write RURAL and give negrest town? e. IS RESIDENCE d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address) ON A FARM? Filled YES NO Headon E 3. NAME OF Middle 4. DATE Year DECEASED OF DEATH Nowember (Type or print) Anderson 28, 1967 9. AGE (In years IF UNDER 1 YEAR 1 IF UNDER 24 HRS. S. SEX DATE OF BIRTH 6. COLOR OR RACE NEVER MARRIED 7. MARRIED lost birthday) Doys DIVORCED WIDOWED Uanuary 22, 188A 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 10a. USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & State, or fareign country) **COUNTRY?** during most of working life, even if retired) INDUSTRY Bullimore USA. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Гета Margarr 17 INFORMAN 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO permit. (Yes, no, or unknown) (If yes give war ar dotes at service 70 212-03-3405 5. Houdow 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). signed by the burial-transit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO signed Conditions, if any, which gave rise to immediate cause (a), DUE TO stating the underlying cause as the priar tal TO HOSPITAL OR ATTENDING PHYSICIAN: The law re Page 4 may be retained by the haspital or attending TO FUNERAL DIRECTOR: After this certificate has been 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO A 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) 20g. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e. PLACE OF INJURY (Home, form, 20f. (City or town) (State) 20d. INJURY OCCURRED (County) 20c. TIME OF INJURY Month, Day, Year factory, street, office bldg., etc.) Not While at wark 21. I certify that (1) (this haspital) attended the deceased fram Lane 20, 1966, to Nov 28, 1967, that (1) (we) last Nov 28 1967, and that death accurred at 6. A. M. fram causes and an the date stated above saw the deceased alive an___ 220 SIGNATURE 22b. DATE SIGNED ATTENDING M.D. DIRECTOR PHYS. 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Eason director, shauld b 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23g. BURIAL CREMATION. (County) (State) REMOVAL (Specify) BUVIR Bullo. 25b. REGISTRAR'S SIGNATURE 2So. REC'D BY REGISTRAR 24. FUNERAL DIRECTOR VR A15 [4] 20 M 1/66 DATE DEC

MARYLAND STATE DEPARTMENT OF HEALTH

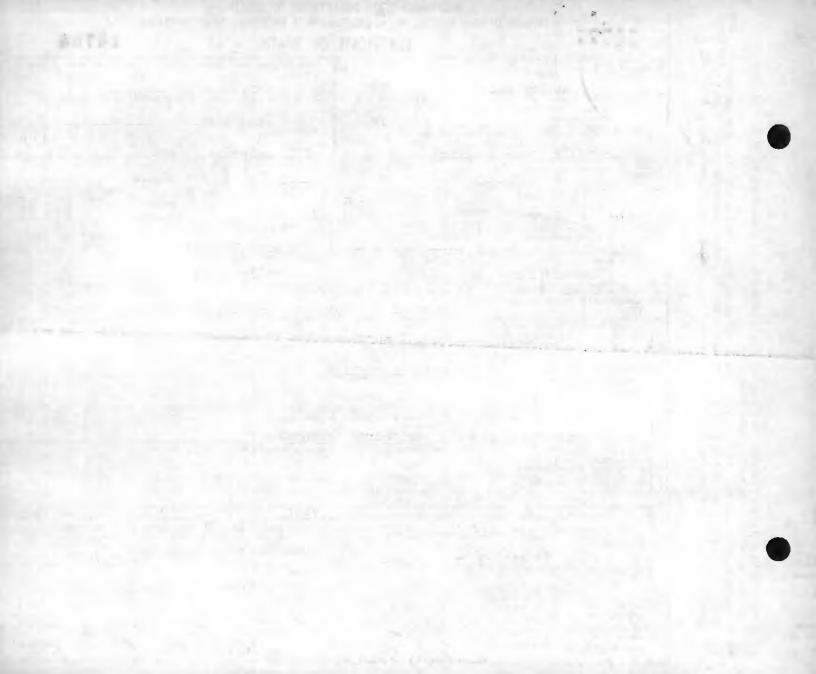


DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14775 16292 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY o. STATE b. COUNTY Anne Arundel Maryland MARYI AND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest fawn) c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b 12 days Baltimore 2 Crownsville d. STREET ADDRESS papers. d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) e. IS RESIDENCE ON A FARM? 16 Market Place Crownsville State Hospital NO T3 YES | NAME OF Middle 4. DATE Month carban tast Day Year campletely DECEASED 19 67 29 event. Edward W. Atkins 11 (Type ar print) DEATH S. SEX 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE B. DATE OF BIRTH 7. MARRIED NEVER MARRIED birthday) Months Davs Hours WIDOWED DIVORCED 3-6-1899 pup 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or fareign country) 12. CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? INDUSTRY physician and Georgetown Delaware None 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME or remayal, Sarah Wilson Allen Atkins IS WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO. (Yes, na, or unknown) (If yes give wor or dates of service) Hospital Records, Crownsville, Maryland 229-05-1783 No crematian, TB. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY: INTERVAL BETWEEN signed by the burial-transit ONSET AND DEATH Respiratory Insufficiency: Pneumonitis IMMEDIATE CAUSE (e) attending physician. DUE TO burial. Conditions, if any, which gave Pulmonary Emphysema rise to immediate cause (a), DUE TO stating the underlying cause the prior to PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPS)
PERFORMED? has far use Health Alcoholism, Chronic NO IX the haspital ar certificate 20g. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part 1 or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH d. (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Hame, form, (City or town) (County) (State) Hour 'a.m. factory, street, office bldg., etc.) Nat While at wark at wark . 1967 to 11/29 21. I certify that (1) (this haspital) attended the deceased from 11/17 . 19 67, that (1) (we) last Page 4 may be retained saw the deceased alive on 21/29/ 1967, and that death accurred at 3:00M, from causes and an the date stated above DIRECTOR: 22a. SIGNATURE 22b. DATE SIGNED M.D. DIRECTOR 11/29/67 22d ADDRESS 27c. PHYSICIAN'S O HOSPITAL NAME (Type) Crownsville State Hospial, Maryland Benedict. 23a. BURIAL, CREMATION 23d. LOCATION (City or Town) 23b. DATE THEREO! 23c. NAME OF CEMETERY OR CREMATORY (County) (State) REMOVAL (Specify) 2-20-6 2 Remova 24. FUNERAL DIRECTOR ADDRESS 2Sq. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATE DEC 2 2 108 W. Washing

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14784 CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 hours after death. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY o. STATE b. COUNTY b. (ITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MARYLAND Maryland c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1h popers. 72 hours Crownsville 8 days Baltimore d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d STREET ADDRESS IS RESIDENC ON A FARM? filled i YES NO-Crownsville State Hospital 227 N. Spring Street 3. NAME OF First Middle 4. DATE Month Doy Year DECEASED (Type or print) Johnny Barnes DEATH 1967 IF UNDER 1 YEAR IF UNDER 24 HRS. S. SEX 6. COLOR OR RACE DATE OF BIRTH 9. AGE (In years 7. MARRIED NEVER MARRIED lost birthdov) Months Dovs Hours WIDOWED DIVORCED and in any 3/15/23 Male Negro and 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? unknown Richmond Virginia IISA 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME or removol, offending phys Edward Barnes Molly Hines IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dates of service) unknown Hospital Records, Crownsville, Maryland no cremofian, INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c),) signed by the burial-transit p PART I DEATH WAS CAUSED BY ONSET AND DEATH Hepatic Insufficiency Cirrhosis of liver DUF TO signed 1 Conditions, if any, which gove Chronic alcoholism rise to immediate couse (a), DUE TO stoting the underlying couse as the the hospital or attending PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19. WAS AUTOPSY hos PERFORMED? detached for use te Dept. of Health Bronchopneumonia; anemia; peripheral neuropathy NO certificate PHYSICIAN: 20b, DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Dov. Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 70f. (City or town) (County) (State) Hour 'e.m. factory, street, office bldg., etc.) While Not While OR ATTENDING at work ot work 21. I certify that (I) (this haspital) attended the deceased from 10/30/ ., 1967, that (I) (we) last , 19 67, to 11/7/ be retoined saw the deceased align an 17/7/ 19 67, and that death accurred at 10:00M, from causes and an the date stated above. DIRECTOR: 220. SIGNATURE 22b. DATE SIGNED STAFF PHYS. DIRECTOR 11/8/67 M.D. PHYS. TO HOSPITAL (Poge 4 may b 22d. ADDRESS 27c. PHYSICIAN'S director, po shauld be f NAME (Type) Crownsville State Hospital, Maryland Ludwig Benedict CEMETERY OR CREMATORY 23d. LOCATION (City of own) (County) 23o. BURIAL, CREMATION (Stote) 24. FUNERAL DIRECTOR 250. RECY BY REGISTRAR REGISTRAR'S SIGNATURE



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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. COUNTY MARYLAND c. LENGTH OF STAY IN 16 autside carparate limits, write RURAL and give negrest town) The law requires that the death certificate be executed within 24-haur e IS RESIDENCE ON A FARM? a NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS NAME OF Middle DATE carban Dov Year etely DECEASED OF and in any event, (Type or print) DEATH IF LINDER 1 YEAR S SEX AGE (In years IF LINDER 24 AR 7 MARRIED NEVER MARRIED remove birthday) Haurs WIDOWED DIVORCED 10b KIND OF BUSINESS OR 12 CITIZEN OF WHA 10a JSUAL OCCUPAT ON (Give kind of work dage BIRTHPLACE (County & State, or foreign country) please COUNTRY OME 13 FATHER crematian, ar removal 17 INFORMANT (Yes, na, or unknown) (If yes give was ar dates at service 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) al-transit PART I DEATH WAS CALSED BY AND DEATH IMMEDIATE CAUSE (a) signed by burial-trans burial-trans DUE TO Conditions, if any, which gave] rise to immediate cause (a), DHE TO stating the underlying couse prior to 19 WAS AUTOPS' PERFORMED? PART 11 OTHER SIGNIFICANT CONDITIONS CONTRIBLITING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(g) NO 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 1 of item 18) 20g. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Manth, Day, Year 20d. INJURY OCCURRED 20e, PLACE OF INJURY (Home, farm, (City or town) (County) (State) Haur a.m. Not While factory, street, office bldg., etc.) at work L at work 21. I certify that (1) (this haspital) attended the deceased from Page 4 may be retained TO FUNERAL DIMICTOR: saw the deceased alive an_ 1967, and that death occurred at 10 Joan, from causes and on the date stated above 22a SIGNATURE 22b DATE SIGNED ATTENDING M.D DIRECTOR **ADDRESS** 22c. PHYSICIAN'S NAME (Type) GED MAD rituacis NAME OF CEMETERY OR CREMATORY 23a BUR AL, CREMATION (Caunty) 250. REC'D BY REGISTRAR VR A15 (4) 25M 1/67



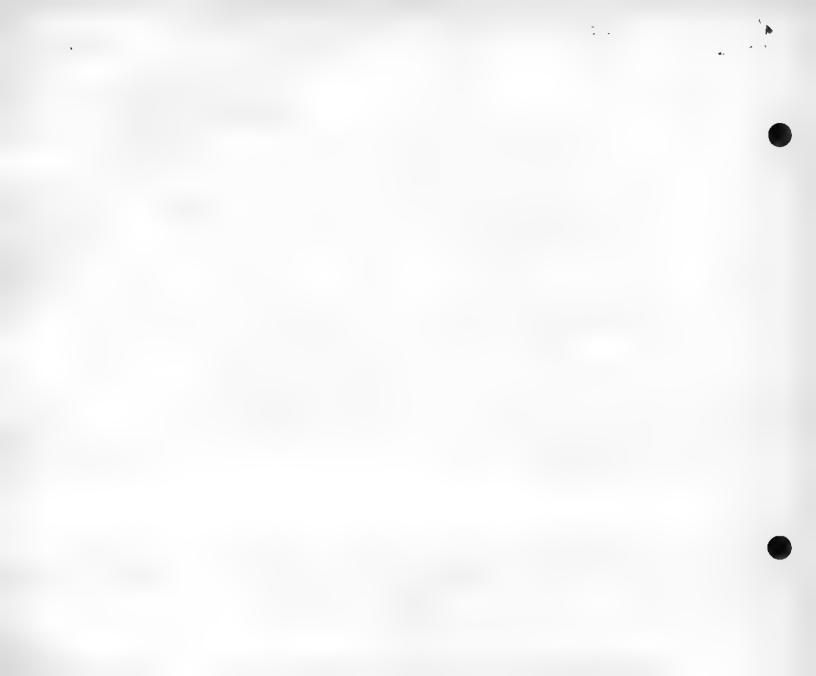
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

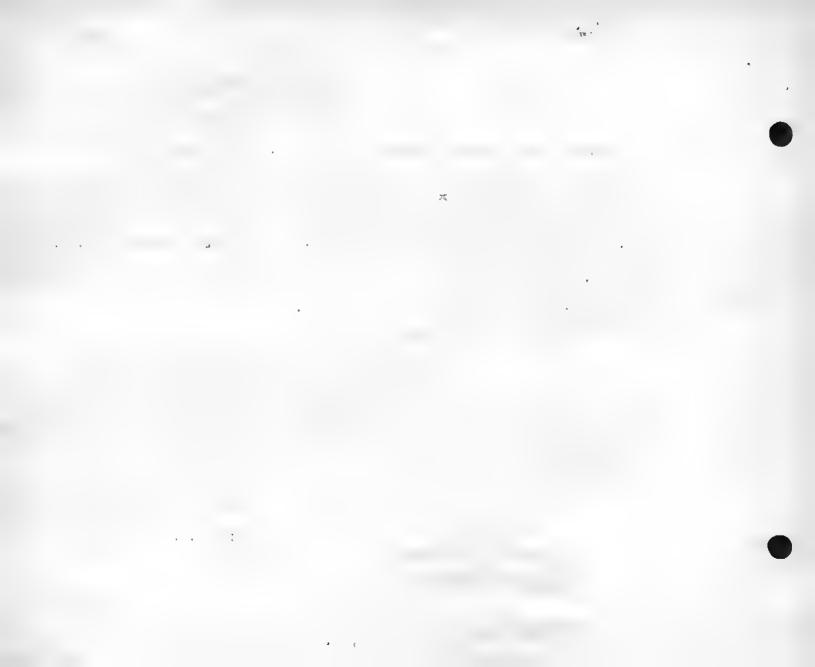
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			18 CAUSE OF DEATH (Enter on y one couse per line for (o), (b), and (c))
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Frer frer frer frer frer frer frer frer			21. I certify that (I) (this haspital) attended the degeased fram 10-10, 19-65, 1a_11-18-67_, 19, that (I) (we) last
ed A A A B			saw the deceased alive an 11-18 1962, and that death accurred at 300M, from causes and an the date stated above
TOR Hard			220 SIGNATURE A 22b DATE SIGNED
OR be related by the second se			MD ATTENDING DIRECTOR
			224 ADDRESS C. 4 O.
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O HOSFITE Page 4 may O FUNERAL director, po		930	BUR AL, CREMATION, 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) (Stote)
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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 14788 law requires that the death certificate be executed within 24 haurs after death 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) 1 PLACE OF DEATH o. COUNTY or STATE b. COUNTY Anne Arundel Maryland MARYLAND b (ITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 16 c CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sunderland Annapolis d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS ON A FARM? and in any event, within 72 YES X NO Anne Arundel General Hospital 3. NAME OF 4 DATE Month Lost Year DECEASED OF DEATH 19 67 BLAKE Pembroke November (Type or pont) Reproe 9. AGE (In years IF JNDER 1 YEAR IF LINDER 24 HRS 6. COLOR OR RACE 7 MARRIED B DATE OF BIRTH 5 SEX **NEVER MARRIED** lost birthdoy) Haues November 19,1913 MIDOWED DIVORCED White Male 1) BIRTHPLACE (County & Stote, or foreign country) 12 CITIZEN OF WHAT TDo _SUAL OCCUPATION (Give kind of work done 1Db KIND OF BUSINESS OR COUNTRY? during most of working life, even if retired) INDUSTRY Maryland U. S. Farming Farmer 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Thomas H. Blake Josephine Pembroke IS WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give wor or dotes of service) 16. SOCIAL SECURITY NO 17. INFORMANT Address 216-18-5309 Mrs. Mary Blake, Sunderland, Maryland No INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) signed by the busided PART I. DEATH WAS CAUSED BY Lamonseles IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gove rise to immediate couse (a). DUF TO stoting the underlying couse 19. WAS AUTOPS PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) PERFORMED? certificate 2Db DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port II of Item 18.) 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 2Dd INJURY OCCURRED 2De, PLACE OF INJURY (Home, form, (City or town) (County) 20c TIME OF INJURY Month, Doy, Year Not While foctory, street, office bldg., etc.) Hour 'a.m. 21. I certify that (I) (this hospital) attended the deceased from 11 - 9 Fage 4 may be retained 19 67, and that death occurred at saw the deceased alive an ram couses and on the date stated above O FUNERAL DIRECTOR: 22b DATE SIGNED 220. SIGNATURE director, page 3 should be filed w DIRECTOR PHYS 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) Annapolis, Maryland Richard F. Maschell 23d LOCATION (City or Town) 23c NAME OF CEMETERY OR CREMATORY 230 BURIAL CREMATION 23b. DATE THEREOF Burial (Specify) Nov. 16.1967 All Saints Chr. Cemetery Sunderland Calvert Md. 25b REGISTRAR'S SIGNATURE Il Limites





MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14783 14790 CERTIFICATE OF DEATH 24 hours after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY n STATE ANNE ARUNDEL MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 6 DAYS CURTIS BAY FT. GEO. G. MEADE. Haltimore. d NAME OF HOSPITAL OR INSTITUT ON (If not in hospital, give street address) d STREET ADDRESS IS RESIDENCE = ON A FARM 4800 CURTIS AVE. KIMBROUGH ARMY HOSPITAL YES NO X PHYSICIAN: The law requires that the death certificate be executed within NAME OF Middle DATE First Lost Doy Year DECEASED OF DEATH NOVEMBER 67 (Type or print) PAULTNE BURLETT BLOOM ar remayal, and in any event, IF UNDER 1 YEAR IF LNDER 24 HRS 6 COLOR OR RACE B DATE OF BIRTH 9 AGE (In years 7 MARRIED NEVER MARRIED Jost birthdoy DIVORCED 22 APRIL 1900 WIDOWED CAU FEMALE 100 LSUAL OCCUPATION (Give kind of work done 10b K ND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT HOUSEWIFE & Duner INDUSTRY COUNTRY? Self- Empolved VTRGINIA 13. FATHER'S NAME
(UNKNOWN) 14. MOTHER'S MAIDEN NAME UNKNOWN KESSLER (Husband) Address IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT (Yes, no, or unknown) (If yes give war or dotes of service) 4800 CURTIS AVE. CURTIS BAY Unknown JOHN BLOOM INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) ONSET AND DEATH PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (0) DIABETES MELLITUS DUE TO Conditions, if any, which gave KIMMELSTIEL WILSON DISEASE rise to immediate couse (a), **DUE TO** stoting the underlying couse WAS AUTOPSY PERFORMED? PART I OTHER SIGNIFICANT CONDITIONS CONTRIBLING TO DEATH BLT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(g) NO DO 200 ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 1B.) (IF EITHER, NOTIFY MEDICAL EXAMINER MEDICAL 20e, PLACE OF INJURY (Home, form (City or town) 20c T.ME OF .N.LRY Month, Day, Year 20d INJURY OCCURRED (County) (Stote) foctory, street, office bldg., etc.) Hour 'o.m. at work 21 I certify that (1) (the observed) attended the deceased from 16 November 19 67, to 23 November 67 that (1) (1) last sow the deceased alive on 22 November 19 67, and that death occurred at 1220AM, from causes and an the date stated above TO HOSPITAL OR ATTEND Page 4 may be retained TO FUNERAL DIRECTOR: 22b DATE SIGNED 220 SIGNATURA 23 Nov 6 director, page should be filed 22d ADDRESS KIMBROUGH ARMY HOSPITAL NAMP (Type) LYNN W. HOLDER, CPT, MC 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) BURIAL, CREMATION (County) (Stote) Nov. 25. GLENHAVEN Memorial Pk GLENBURNIE. MD. Singleton Funeral Home 2So RECD BY REGISTRAR 25b REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR Glen Burnie Maruland



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14791

14784

CERTIFICATE OF DEATH

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the the		saw the deceased olivern Nov 18 19 6 7, and that death	occurred at 430 M, fram causes and an the date stated above
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			ADDRESS / + D D (SCP. BUT)
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O HOSPIN Poge 4 m O FUNER, director,	230	30 BUR AL, CREMATION, 236 DATE THEREOF 23c NAME OF CEMETERY OR CREMATO	RY 23d LOCATION (City or Town) (County) (State)
Poge direct		REMOVAL(Specify) 11 21 1.967 St. Andrews	German Hill Rd. : Itcd.
	2	24 FUNERAL DIRECTOR ADDRESS	250 REC D. BY REGISTRAR 25h REGISTRAR'S SIGNATURE
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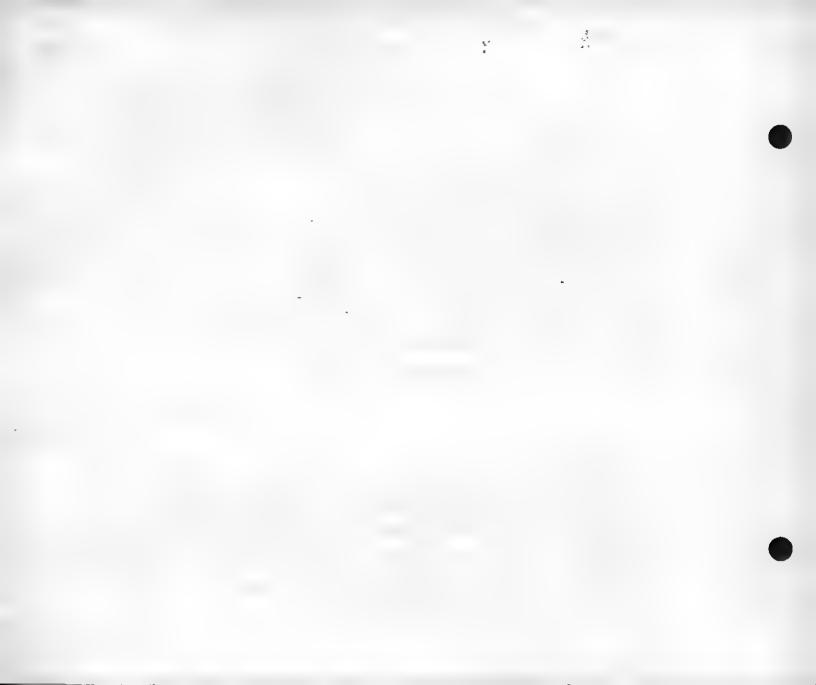


MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14792 14785 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 paurs after death funeral 1 and PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o COUNTY. MARYLAND b CITY OR TOWN (If autside carparate limits € LENGTH OF STAY IN 1b CITY OR TOWN (if autside carparate simits, write RURAL and give negrest tawn) rite RURAL and Give nearest tawn) 1/2 mo: d NAME OF HOSPITA. OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS remave carban appers ON A FARM? NO . 3 NAME OF Middle Year Day DECEASED OF DEATH SEORGE (Type or print) S SEX 6 COLOR OR RACE 7 MARRIED AGE (n years FUNDER I YEAR NEVER MARRIED buthday) Months Days Haurs WIDOWED DIVORCED 10a USUAL OCCUPATION (Give kind of work done 106 KIND OF BUSINESS OR 12 CITIZEN OF WHAT physician a ien please during mast of working life, even if retired) OLICEMAN 13. FATHERS NAM ar remayal, 16 SOCIAL SECURITY NO. 17 INFORMANT (Yes, no, or inknown) (If yes give wor or dates of service 1B. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) INTERVAL BETWEEN signed by the burial-transit p burial, cremati PART F DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Cand a ans, if any, which gave rise to immediate cause (a), DUE TO stating the underlying cause the th PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(G) WAS AUTOPSY PERFORMED? 20g ACCIDENT WAS UNDERLYING ☐ OR CONTR.B..T.NG ☐ CAUSE OF DEATH 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Port I of item 3B) letached for Dept. af H (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Day, Year 20d INJJRY OCCURRED 20e PLACE OF INJURY (Hame, farm, 20f (City or town) (County) (Stote) Haur a.m factory, street, office olda, etc.) Not While ATTENDING DIRECTOR: After 21. I certify that (I) (this hospital) attended, the deceased from the be retained and that death accurred at CYSOM from causes and an the date stated above 1967 saw the deceased alive an Clov 22a. SIGNATURE 22b DATE SIGNED ATTENDING M.D. PHYS DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S TO FUNERAL NAME (Type) BURIAL, CREMATION. DATE THEREOF LOCATION, (City or Town **BUNERAL DIRECTOR** 2Sq RECD BY REGISTRAR 2Sb. REGISTRAR'S SIGNATUR VR A15 (4)





MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14787 14794 CERTIFICATE OF DEATH PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence perfore admission) a COUNTY q. STATE b COUNTY MARYLAND 24 hours ofter c LENGTH OF STAY IN 16 c CITY OR TOWN (If outs de corporate limits, write RURAL and give nearest tawn) b. CITY OR TOWN (If outside corporate imits, write RuRAL and give nearest town) hours HICUI d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) .⊑ d STREET ADDRESS e IS RESIDENCE ON A FARM pletely-filled carbon pap □ NO V YES The law requires that the death certificate be executed within NAME OF First Middle Manth Year DECEASED (Type or print) NOU cremation, or removal, and in any event 196 DEATH S SEX AGE (In years last birthday) IF UNDER 1 YEAR UNDER 24 HRS 7 MARRIED NEVER MARRÍED гетоме Months Hours DEWOOD DIVORCED 10a USLAL OCCUPATION (Give kind of work dane 10b. KIND OF BUSINESS OR 12 CITIZEN OF WHAT pleose COUNTRY? 13 EATHERS NAME 16 SOCIAL SECURITY NO INFORMANT (Yes, ng, ar unknown) (If yes give wor or dotes af service /18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c),) INTERVAL BETWEEN signed by the burnel-tronsit PART I. DEATH WAS CAUSED BY. ONSET AND DEATH IMMEDIATE CAUSE (a) DUE TO Canditions, if any, which gave rise to immediate cause (a), DUE TO for use as the t Health priar to b stating the underlying cause Page 4 may be retained by the hospital or attending last. 19 WAS AUTOPSY PERFORMED? certificate hos PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN, IN PART 1(a) NO 20a ACCIDENT WAS INDERLYING [1] 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port II of item 18) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER 20c. IIME OF INJURY Month, Day, Year 20d INJURY OFCURRED 20e. PLACE OF INJURY (Home, form, (City or fown) (County) (Stote) Haur o.m. Not White foctory, street, office bldg., etc.) ot work at wark 21. I certify that (I) (this haspital) attended the deceased fram 1933 and that death accurred at // M, fram causes and an the date stated above FUNERAL DIRECTOR: saw the deceased alive an 22a SIGNATURE 226 DATE SIGNED STAFF DIRECTOR M.D. 22c. PHYSICIAN'S 22d. _ADDRESS NAME (Type) director, p 23b . DATE THEREOF NAME OF CEMETERY OR CREMATORY BURIAL, CREMATION 2 2So. REC'D BY REGISTRAR FUNERAL DIRECTOR **ADDRESS** DATE NOV VR A15 (4) 25M 1/67



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death

Page 4 may be retained by the haspital ar attending physician.

VR A15 (4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the tall director, page 3 should be detached for use as the burial-transit permit. Then please remaye carban papers. Pages should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, with MM-72 hours after

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14795

14788

CERTIFICATE OF DEATH

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4	OR CONTRIBUTING CAUSE OF DEATH											
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-	22c. PHYSICIAN'S					22d. ADDRESS						
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	DIVISION OF HITALIREGORDS, 301 W GRESTON-STREET, BALTIMORE, MARYLAND 21201 14756	
2 FOR STATE	14789 MEDICAL EXAMINER'S CERTIFICATE OF DEATH	
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del del	b CITY DR TOWN (I guide corporate limits. C LENGTH OF STAY IN 1b C CITY OR TOWN N outside corporate limits write RURAL and give nearest town) Which IRAL and give nearest town	
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Medical Examplease execute the director. Page 4 retained for your. DIRECTOR: Page in to build, cremainto to build the community of the communi	21. I certify that I tack charge af the remains described above held an Autopsy, Inspection, Inquiry, and in my apir death resulted from, board causes, Accident, Suicide, Homicide, Undetermined manner	noir
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	aw reciding posen si		stating the underlying cause lost.	
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	NG PH) I the he er this e detect of Dep	MEDICAL	Haur a.m. p.m. 19 While at wark at wark factory, street, affice bldg., etc.)	County) (State)
	TENDIA Ined by IR: Affi Sould be the St			the date stated above.
	OR ATTENDING be retained by the INECTOR: After e 3 should be de ed with the State		Toler MD ATTENDING MED. STAFF DIRECTOR PHYS.	DATE SIGNED
	PITAL t may t ERAL D or, pag d be file		1221 PHYSICIAN'S NAME (Type) Robert R. HAHN . 22d ADDRESS BOX 73 Several	Bub
	TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires the Page 4 may be retained by the hospital or attending physician. To FUNERAL DIRECTOR: After this certificate has been signal director, page 3 should be defacthed for use as the burnol-tron should be filed with the State Dept. of Health prior to buriol, creasing the prior of the state buriol, creasing the prior of the state buriol, creasing the state of the state burior	230	BUR AL, CREMATION, 23b. DATE THEREOF 23c NAME OF CEMETERY OF GREMATORY 23d LOCATION (City or Town) REMOVAL (Specify) (1-14-67 CHRIST CHURCH OWENSUIL)	(Caunty) (State)
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\times 1		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201	
FOR STATE		14791 MEDICAL EXAMINER'S CERTIFICATE OF DEATH	14799
HEALTH BERT		PLACE OF DEATH O COUNTY MARYLAND 2 USUAL RESTORMENCE (We'ge'e deceosed lived, if institution on STATE) b. COUNTY D.	1 Class
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ges 1, form	1	D. O.A. M. L. Beneral Zille Ko	CLC e IS RESIDENCE ON A FARM? YES NO
er deal live Pai ig with	3	NAME OF DECEASED (Type or print) William Butter of DEATH Month	Doy Year 2 / 1967 IF UNDER 1 YEAR IF UNDER 24 HRS
d within 24 hours ofter death If in pencil in Item 18. Give Pages 1, Examiners Office along with form File pages land 2 with the State Death.	2	MULC COC- WIDOWED DVORCED 1-14-146/66 VIS	Months Doys Hours Min
24 hou in Item rs Offi es landes	dur	. USUAL OCCUPATION (Give kind of work done industrial) 10b KIND OF BUSINESS OR 11_ BIRTHPLACE (State or foreign country) INDUSTRY	COUNTRY?
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	15	was Deceased Ever in S armed Forces? 16 SOC A SECURITY NO 17 INFORMANT Address 17 INFORMANT 18 SOC A SECURITY NO 17 INFORMANT 18 SOC A SECURITY NO 17 INFORMANT 19 INFORMANT 10 SOC A SECURITY NO 17 INFORMANT 10 SOC A SECURITY NO 17 INFORMANT 10 SOC A SECURITY NO 17 INFORMANT 11 INFORMANT	rister 11/6
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e shauld be e the word "per ta the Chief? i burial-transit in any event v		Conditions, if ony, which gove (b)	Meledie
vert ficate shauld writing the word rwarded to the Cf sed as a burial-tr val, and in any ev		stoting the underlying couse DUE TO lost.	
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1000年代 1000年 1000	MEDICA	20c TIME OF INJURY Month, Doy, Year Hour o.m. p m 19 20d N.J.RY OCCURRED 20e PLACE OF NJURY (Home, form form) While of work of work of work of work	(founty) (State)
* × × × × × × × × × × × × × × × × × × ×		21. I certify that I taak charge of the remains described above, held an Autapsy [], Inspect an [], Inqui death resulted froms, Natural causes [], Accident [X], Suicide [], Hamicide [], Undetermined ma	ry
		ACTUAL SIGNATURE ASS STANT MEDICAL EXAMINER ASS STANT MEDICAL EXAMINER	22. DATE SIGNED
O DEPUTY Interest of the funeral of FUNERAL Heath prior		EXAMINER'S NAME (Type) E.L. har of DEPUTY MFD CAL EXAMINER Address (Street, c.l.y., town, or county)	11-21-67
To Fine C	230	BUR AT TREMATION, 236 DATE THEREOF 23 NAME OF TEMETERY OR CREMATIONY (23d OCATION CITY OF TOWN 25 MAY 1 Specify CITY OF TOWN 25 OCATION CITY OCATION C	ille Me
VR ATSME	1 /		STRAR'S SIGNATURE

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14792. 14800 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) deat o. COUNTY n STATE b. COUNTY Anne Arundel Anne Arundel Maryland b CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) c. CITY OR TOWN (If outside corparate limits, write RURA, and give necrest town) c. LENGTH OF STAY IN 1b Annapolis Annapolis d NAME OF HOSP TAL OR INSTITUT ON (If not in haspital, give street address) e IS RESIDENCE ON A FARM? d STREET ADDRESS Anne Arundel General Hospital 160 Prince George Street YES NO X 3 NAME OF Middle 4 DATE DECEASED OF DEATH CLAUDE 1967 Chardotte Whalev November (Type or print) S SEX FUNDER LYEAR IF UNDER 24 HRS 6 COLOR OR RACE 7 MARRIED X NEVER MARRIED 8 DATE OF BIRTH 9 AGE (In years last by hday) Months November 30, 1897 WIDOWED DIVORCED White Female. IDo LSUAL OCCUPATION (Give kind of wark done during most of work ng lite, even if retired) 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT 11 BIRTHPLACE (Coupty & State of Fareign country) INDUSTRY COUNTRY? TOMEWILE AUTOW. Ohio U.S. 13. FATHER 14 MOTHER S MAIDEN NAME burial, crematian, or remayal, 16 SOCIAL SECURITY NO , INFORMANI (Yes, no, ar unknawn) (If yes give war ar dates of service) 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) INTERVAL BETWEEN signed by the burick-transit p PART I. DEATH WAS CAUSED BY: ONSET AND DEATH IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), DUE TO stating the underlying cause 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIF.CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO X 20a ACC DENT WAS UNDERLYING [20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part II of Item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20d INJURY OCCURRED 2De. PLACE OF INJURY (Hame, farm, (City ar tawn) (Caunty) (State) 2Dc TIME OF INJURY Month, Day, Year **DIRECTOR:** After this foctory, street, office bidg., etc.) Not While at wark to Nov. 17 , 1967, that (I) (NAS) last 2]. I certify that (1) ANNOTED (1) attended the deceased from . 19. and that death accurred at_ M, fram causes and an the date stated above saw the deceased alive an_ 220 SIGNATURE 22b DATE SIGNED ATTENDING DIRECTOR 22c. PHYSICIAN 22d ADDRESS O FUNERAL NAME (Type) Stephen B. Hiltabidle, M.D. 121 Cathedral Street, Annapolis, Md. 23a BURIAL CREMATION 23b DATE THEREOF OF CEMETERY OR CREMATORY 23d. _LOCATION (City or Town) VR A15 (4)



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14793 CERTIFICATE OF DEATH death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) unera o. COUNTY o. STATE b. COUNTY Anne Arunde I
b CITY OR TOWN (If outside corporate limits,
write RURAL and give nearest town) Maryland Anne Arundel MARYLAND OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 Annapolis 3 vears Annapolis d NAME OF HOSPITAL OR INSTITUTION (If not in hospito, give street oddress) d STREET ADDRESS e IS RESIDENCE burial, cremation, or removal, and in any event, within 72 campletely filled 52 W. Washington St. Anne Arundel General Hospital NO T remove carban 3 NAME OF Lost 4. DATE Month Dov Year DECEASED 1967 COLE November (Type or print) Charles Franklin DEATH 9 AGE (In years IF UNDER IF UNDER 24 HRS S SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED B DATE OF BIRTH 60 yrs Months April 10, 1907 WIDOWED DIVORCED Male Negro 10o USUAL OCCUPAT ON (Give kind of work done 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT 10b KIND OF BUSINESS OR during most of working life, even if retired)

Chauffuer COUNTRY? attending physician (permit. Then please A.A.Co Md

14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME Mary Anderson Thomas Cole INFORMANT 15 WAS DECEASED EVER IN U.S. ARMED FORCES? Address Anna, Md 16. SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give wor or dates of service) Mary A. Butler 1184 Bresident st 214-05-2120 No INTERVAL BETWEEN IB. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c). signed by the burial-transit p PART I DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (o Page 4 may be retained by the haspital ar attending physician. DUE TO Conditions, if any, which gove nse to immediate couse (a), DUE TO stoting the underlying couse as the has been last WAS AUTOPS? PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) CERT F CATION NO 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 200 ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20e PLACE OF INJURY (Home, form, (City or fown) (County) (Stote) 20c. TIME OF INJURY Month, Day, Year factory, street, office bldg., etc.) of work TO FUNERAL DIRECTOR: After ta /1-4-67, 19_, that (I) (we) last 21. I certify that (1) (this haspita) attended the deceased from 11-3-67 director, page 3 shauld should be filed with the 11-4-67. 19 and that death accurred at 630 _M, fram causes and an the date stated above. saw the deceased alive an_ 220 SIGNATURE 22b. DATE SIGNED **ATTENDING** DIRECTOR PHYSIC AN S 22d. ADDRESS Severna Park, Md. NAME (Type) ROBERT R. HAHN, MD 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) BURIAL, CREMATION (County) (Stote) REMOVAL (Specify) A.A.Co Md Brewer Hill Annapolis 11-7-67 Burial

24 FUNERAL DIRECTOR 2So REC'D BY REGISTRAR 25b. REGISTRAR S SIGNATUR VR A15 (4) C. E. Hicks. 111 Annapolis, Md Munico





MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14503 CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 hours after death. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission a. COUNTY o. STATE b. COUNTY Anne Arundel Maryland MARYLAND b (ITY DR TDWN (If outside corporate limits write RURAL and give nearest town) Crownsvile c LENGTH OF STAY IN 16 c CITY OR TOWN (If autside carporete limits, write RURAL and give negrest town) Baltimore 30 d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e IS RESIDENCE ON A FARM? peper: him 72 Crownsville State Hospital 1515 Barclay Street within YES NO NAME OF Middle pau First Last 4 DATE Manth Year Day DECEASED OF Cheeks Lee Cooper 19 67 (Type or print) Dera 11 event, DEATH remave car S SEX 6. COLOR OR RACE 8 DATE OF BIRTH 9. AGE (n years IF UNDER 1 YEAR 7 MARRIED NEVER MARRIED IF JNDER 24 HRS last birthday) Months Haurs and in any 9/6/24 WIDOWED DIVORCED Negro guq IDa. USUAL OCCUPATION (Give kind of work done IDE KIND OF BUSINESS DR 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of working life even if retired) Newspeaner COUNTRY? South Hill . Virginia 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME burial, crematian, ar remaval, Willie Jane Reid Landon Cheeks Sr. 15. WAS DECEASED EVER IN ILS ARMED FORCES? 17 INFORMANT 16. SDCIAL SECURITY NO. Address (Yes, na, or unknown) (If yes give war ar dates of service unknown Hospital Records, Crownsville, Maryland 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c),) INTERVAL BETWEEN burial-transit PART I, DEATH WAS CAUSED BY DINSET AND DEATH Chronic Alcoholism IMMEDIATE CAUSE (a) Page 4 may be retained by the haspital or attending physician 3221 DUE TO signed l Conditions, if any, which gave (b) rise to immediate couse (a). DUE TO stating the underlying cause as the prior take 19 WAS AUTOPSY PERFORMED? hos PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(g) Health ; Chronic Brain Syndrome; Malnutrition' NO certificate è 2Do ACCIDENT WAS UNDERLY NO [7] 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 2Dc. TIME OF INJURY Month, Day, Year 204 INJURY OCCURRED 2De PLACE OF INJURY (Home, farm, (Eity or town) (County) (State) factory, street, affice bldg , etc.) Not While at work 21 I certify that (I) (this haspital) attended the deceased fram. 4/19/ 11/ 25 , 19 67 that (1) (we) last 19 66 ta saw the deceased alive an 11/25/ 19.67 and that death accurred at 6:00M, from causes and on the date stated above. DIRECTOR: page 3 shau be filed with t 22a SIGNATURE 225 DATE SIGNED STAFF 11/27/67 DIRECTOR M D PHYS 22d ADDRESS 27c. PHYSICIAN'S FUNERAL NAME (Type) Ludwig Benedict, M.D. Crownsville State Hospital, Maryland 23a. BJRIAL, CREMATION 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) rect (County) (Stote) Mt. Auburn Cemetery Baltimore. Maryland 24 FUNERAL DIRECTOR 2Sq REC'D BY REGISTRAR 2Sb REGISTRAR'S SIGNATURE Herbert E. Nutter-3035 W. North Ave. 1967 DEC DATE



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14864 14798 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 1 PLACE OF DEATH n COHNTY 5. COUNTY 17.11. Ce MACO Page c JENGTH OF STAY IN 15 b CTY OR TOWN (If outside comporate mits c (ITY OR TOWN (I outside corporate mits write RURAL and give nearest town) 2, and PM3. Yen BURNIE. EN BURIVIE d STREET ADDRESS OR NSTITUTION (If not in hospital, give street address) 124 NORTH CEAIN High. YES 🗌 NO N 24 haurs after death. 4 DATE NAME OF Middle Month DECEASED OF DEATH 19 67 (Type or print) IF UNDER 1 YEAR IF L'NDER 24 HRS 9 AGE (n years 7 MARR ED NEVER MARR ED buthdoy) DIVORCED WIDOWED 12 CITIZEN OF WHAT 10p USUA, OCCUPATION (Give kind of work done 11 B RTHPLACE (State or fore an country) during most of working feeven if retired) Choedrocel 13 FATHER'S NAME ba executed within IS WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) ((If yes give wor or dotes of service)) 16 SOCIAL SECURITY NO within 72 18 CAUSE OF DEATH 'Enter only one couse per line for (o), (b) and (c) NTERVA. BETWEEN ONSET AND DEATH PART I DEATH WAS CAUSED BY. arlerio Delenario IMMEDIATE CAUSE (o) This cert ficate shauld DUE TO Conditions, if ony, which gove rise to immediate cause (o). DUE TO stoting the underlying couse 0.5 PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPS' PERFORMED? NO F 200 EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port I of tem 18) 3 shauld PRIMARY IT or CONTRIBUTING IT CAUSE OF DEATH 20e PLACE OF INJURY (Home form 20f rCity town 20d INJURY OCCURRED 20c TIME OF INJURY Month Doy, Year foctory, street, office bldg., etc.) Hour o.m. While ____ Not While may be retained far yaur FUNERAL DIRECTOR: Page of work 21. I certify that I took charge of the remoins described above held on Autapsy [7], Inspection [8] Inquiry X. and in my opinion Natural causes Accident Surcide Undetermined manner death resulted from Homicide TO FUNERAL DIRE CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MED CAL EXAM NER SIGNATURE the funeral DEPUTY MEDICAL EXAMINER **EXAMINER'S** Address (Street city town or rounty) NAME (Type) BUR A. (REMATION, NAME OF CEMETERY OR CREMATORY REMOVAL (Specify) VR A 15ME (5) DATE NOV 1



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 4 6797 CERTIFICATE OF DEATH 14865 The law requires that the death certificate be executed within 24 haurs after death 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission.) PLACE OF DEATH **b.** COUNTY o. COUNTY o STATE Anne Arundel MARYLAND Maryland b City OR TOWN (If outside corporate I mits, write RURAL and give nearest tawn)
Crownsville CLENGTH OF STAY IN 15 c CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 19 days Glen Burnie e. IS RESIDENCE d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) A STREET ADDRESS ON A FARM? Crownsville State Hospital NO 406 Morris Hill Avenue Middle Lost 4 DATE NAME OF Eirst DECEASED Wilton DEATH attending physician and camplete permit. Then please remove car on, ar remaval, and in any event, (Type or print) Henry Crawlev IF UNDER 24 HRS IF JNDER I YEAR 6 COLOR OR RACE DATE OF BIRTH 9 AGE (in years S. SEX 7 MARRIED NEVER MARRIED ast birthday) Months Haurs WIDOWED DIVORCED 7/19/00 Male Negro 12 CITIZEN OF WHAT 10a JSUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) **COUNTRY?** during most of working life, even if retired)
Musician INDUSTRY Virginia TISA 14. MOTHER'S MAIDEN NAME 13 FATHER'S NAME burial, cremation, ar remaval, William Crawley Katy Drew 16 SOCIAL SECURITY NO 17. INFORMANT Address 15 WAS DECEASED EVER IN U.S. ARMED FORCES? permit. (Yes, no, ar unknown) (If yes give war or dates of service) Hospital Records, Crownsville, Maryland no unknown INTERVAL BETWEEN 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c),) signed by the burial-transit p PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE (AUSE (a) Uremia Chronic remal failure: Acute pvelonephritis Page 4 may be retained by the haspital ar attending physician. Conditions, if any, which gave (b) Hypertensive cardio vascular disease rise to immediate cause (a), DUE TO stoting the underlying couse as the prior tal lost WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE COND T ON GIVEN IN PART 1(c) be detached far use State Dept. of Health p NO F Chronic Brain Syndrome this certificate PHYSICIAN: 20a ACC DENT WAS UNDERLYING [20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e PLACE OF INJURY (Home, farm, 20f (City or town) (Caunty) (State) 20d INJURY OCCURRED 20c. TIME OF INJURY Month, Doy, Year factory, street, affice bldg, etc.) Haur 'a.m. Nat While OR ATTENDING at work at work **DIRECTOR:** After 1967, that (I) (we) last 1967_. to 11/5 21. 1 certify that (1) (this haspital) attended the deceased fram. 10/17 director, page 3 should should be filed with the 19 67, and that death accurred at 7:55 M, fram causes and an the date stated above. saw the deceased alive an /// 22b. DATE SIGNED 22a SIGNATURE TX PHYS. **ATTENDING** DIRECTOR M.D. PHYS. 22d. ADDRESS 22c. PHYSICIAN S FUNERAL NAME (Type) L. Benedict, M.D. Crownsville State Hospital, Maryland 230 BURIAL, CREMATION, 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) (State) 23b DATE THEREOF REMOVAL (Specify) Baltimore Maryland
GISTRAR 256 REGISTRAR S SIGNATURE Auburn 9 Nov. 7. 67 ADDRESS 25g REC'D BY REGISTRAR 24. FUNERAL DIRECTOR 1967 VR A15 (4) 25M 1/67 Charles R. Law 802 Madison Ave.

MARYLAND STATE DEPARTMENT OF HEALTH



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 14866 deoth 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) PLACE OF DEATH o. COUNTY Anne Arundel b. COUNTY o. STATE Maryland MARYLAND 24 hours after b CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest lown) C LENGTH OF STAY IN 16 22 days Crowns ville 22 d Glen Burnie d STREET ADDRESS B IS RESIDENCE ON A FARM? YES NO K 21 Ferndale Ave. Crownsville State Hosnital The law requires that the death certificate be executed within 3 NAME OF M≀ddle Last A DATE Month Doy Year DECEASED
(Type or print) 167 gremation, or removol, and in any event, DEATH Crum Edith FUNDER 1 YEAR IF UNDER 24 HRS S. SEX 6 COLOR OR RACE NEVER MARRIED DATE OF BIRTH AGE (In years 7. MARRIED ast birthday) Manths Days WIDOWED DIVORCED 8/11/84 White Female. physician and 10a USUA. OCCUPATION (Give kind of work dane during most of working life, even if retired) 12. CITIZEN OF WHAT 11. BIRTHPLACE (County & State, as foreign country) JOB K ND OF BUSINESS OR COUNTRY? please INDUSTRY Indiana None 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Lily Townsend James Hawes IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give war or dates of service) Hospital Records, Crownsville, Maryland 232-28-2101 INTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY. signed by the buriol-tronsit p buriol, cremati ONSET AND DEATH Acute coronary Insufficiency IMMEDIATE CAUSE (a) ____ DUE TO Arteriosclerotic Cardio vascular disease Conditions, if any, which gave rise to immediate couse (o). **DUE TO** stating the underlying cause the 19. WAS AUTOPS'
PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO E Chronic Brain Syndrome O FUNERAL DIRECTOR: After this certificate PHYSICIAN: 20g ACCIDENT WAS UNDERLYING 205. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e PLACE OF INJURY (Home, form, (City or town) (County) (State) 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED foctory, street, office bldg., etc.) Not While at wark of work L 21. I certify that (I) (this haspital) attended the deceased from 10/18 , 19 67, to 11/9 , 1957, that (I) (we) lost 1967, and that deoth occurred of : 30 M, fram couses and on the date stated above. saw the deceased alive on 11/9/ 22b. DATE SIGNED 22a. SIGNATURE ATTENDING 11/9/67 DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Crownsville, State Hospital, Maryland Benedict 23d. LOCATION (City or Town) 23o. BURIAL, CREMATION, 23b DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY (County) REMOVAL (Specify) Glen Burnie Glen Haven Memorial Park 24 FUNERAL DIRECTOR 2Sq REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE DATENOV Mirkley Funeral Home, Glen burnie, id.

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14867 CERTIFICATE OF DEATH 44799 requires that the death certificate be executed within 24 haurs after death. USUAL RESIDENCE (Where deceosed lived, if institution. Residence before admission) PLACE OF DEATH a COUNTY o. STATE b. COUNTY Anne Arundel MARYLAND b CITY OR TOWN (if outside corporate limits, C LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURA, and give necrest town) write RURA, and give nearest town) Washington, D. C. 6 vrs. 6 mos. d NAME OF MOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e IS RESIDENCE ON A FARM? Family and Child Services Children's Center Hospital YES NO 124 NAME OF 4 DATE FIFST Middle Lost Year DECEASED Cusic 19 67 November 25, Dana (Type or print) DEATH AGE (In years lost perthdoy) F UNDER 1 YEAR S SEX 8. DATE OF BIRTH IF JNDER 24 HRS 6. COLOR OR RACE 7. MARRIED NEVER MARRIED Hours White 11-11-59 Female WIDOWED DIVORCED 100 USUAL OCCUPAT ON (Give kind of work done 11. BIRTHPLACE (County & Stote, or foreign country) 12 CITIZEN OF WHAT 10b KIND OF BUSINESS OR COUNTRY? dur ng most of work na lite, even if tetired)
INSTITUTIONALIZED INDUSTRY Washington, D. C. 14. MOTHER'S MAIDEN NAME Anita Marie Patterson 13. FATHER'S NAME Unknown 16. SOCIAL SECURITY NO. 17 INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Jaknown) (If yes give war or dotes of service N/A Children's Center Hospital, Laurel, Md. INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) ONSET AND DEATH burial-transit PART I, DEATH WAS CAUSED BY-Bronchopneumonia IMMEDIATE CAUSE (o) DUE TO Spastic quadriplegia - cerebral agenesis Conditions, if any, which gove rise to immediate couse (a), DUE TO stoting the underlying couse O FUNERAL DIRECTOR: After this certificate has been the the Convulsive disorder 19. WAS AUTOPS!
PERFORMED? PART IT OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(4) NO PC ģ 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18.) 200 ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or fown) (County) (State) 20c TIME OF INJURY Month, Doy, Year foctory, street, office bldg., etc.) 2). I certify that (I) (this haspital) attended the deceased fram May 18 saw the deceased alive an November 2519 67, and that death according to the deceased of the deceased 1961 to November 25 67 that (I) (we) last and that death accurred at 2:50 pm, fram causes and an the date stated above 22b. DATE SIGNED 22o. SIGNATURE **ATTENDING** MED. DIRECTOR M.O. PHYS director, page should be filed 224 ADDRESS Children's Center Hospital, Laurel, Md. 22c. PHYSICIAN'S JAMES E. BOYLAND, M. D. NAME (Type 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 230 BURIAL, CREMATION, REMOVAL (Specify) 23b DATE THEREOF (County) (Stote) Md. Laurel 11-29-67 Children's Center ADDRESS 2Sb. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR 250 REC'O BY REGISTRAR VR A15 (4) Donaldson 1 1 100



1	DIVISION OF VITAL RECORDS, 301 W. PRESTON	
	14800 CERTIFICATE O	DE DEATH
(NAFe = =	1. PLACE OF DEATH	USUAL RESIDENCE (Where deceosed lived, finistitution Residence before admission)
funerol day	o COUNTY	o STATE
10 P	Anne Arundel MARYLAND	Maryland Anne Arundel
by the Pope	b. CITY OR TOWN (If outside corporate mits, c LENGTH OF STAY IN 1b c write RURAL and give nearest town)	CITY OR TOWN (if outside corparate limits, write RURAL and give nearest town)
19 A 19	Annapolis 4 hrs.	RURAL - Edgewater
d in ders		STREET ADDRESS B IS RESIDENCE ON A FARM?
illed in 74 h	Anne Arundel General Hospital	Rt-3, Box-759
completely filled in by the cove corbon papers Pages y event, within 71 hours of	3 NAME OF First Middle	Last 4 DATE Month Day Year
d v d v		DAVIS DEATH November 6 1967
mp ve (ve (PATE OF BIRTH 9 AGE (n years FUNDER YEAR IF UNDER 24 HRS 1 tost birthday Months Days Hours Mun
J co mo	Male White WIDOWED DIVORCED NO	ov. 6, 1967 lost birthdoy) Months Doys Hours Min
and and in o	10o. USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 1	1 BIRTHPLACE (County & State or foreign country) 12 C TIZEN OF WHAT
ion ion ond	during most of working life, even if retired) INDUSTRY Newborn	Anne Arundel, Maryland (COUNTRY?)
Pks Pks		MOTHER'S MAIDEN NAME
ph ph	WILLARD K. DAVIS	CARCLA H. WAFR
Ten The	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFO	RMANT Address
ded tenu y, or	(Yes, no, or unknown) (If yes give war or dotes of service)	LDOB R. DAVIS #2
equires that the death certificate be executed within 24 physician. Signed by the ottending physician and completely filled buriol-transit permit. Then please remove carbon pape buriol, cremation, or removal, and in any event, within 7.	18. CAUSE OF DEATH (Enter only one couse per line for (g), (b) and (c))	INTERVAL BETWEEN
th isit	PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (0)	fartere ONSET AND DEATH
the side of the state of the st	7730 DUE TO 1/10	0) /
yside gnec riol	Conditions, if ony, which gove) (b) Gracille Leven	trace discere 6 times
a sicon	nse to immediate couse (a), stating the underlying couse DUE TO	
e law re trending 3s been os the prior to	last. (c)	
by the hospital or ottending physician. Ite this certificate has been signed by the ottending physician and completely filled in by the funeral be detached for use as the buriol-transit permit. Then please remove corban papers? Pages I and State Dept. of Health prior to buriol, cremation, or removal, and in any event, within 7th outsafth dept.	DADT II OTHER S CHIEFCANT CONDITIONS CONTRIBUTING TO BEATLY BUT NOT RELATED TO THE	TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS ALTOPSY PERFORMED?
PHYSICIAN: The he hospital or ott this certificate has letached for use letached for use bept. of Health p	NAME IN OTHER 3 GRIFFICARS CONDITIONS CONTRIBUTING TO DERIVE BUT NOT RELATED TO THE	YES TON NO
AN. all o all o for the chart	206 DESCRIBE HOW NURY OCCURRED (Epite	er noture of injury in Port I or Port II of item 18)
SICI Spit Spit Spit Spit Spit Spit Spit Spit	206 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CLAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
PHYSIC ne hospi ne hospi his cert his cert Dept. o	20c T ME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE O	FINJURY (Home, form, 20f (City or town) (County) (State)
det the det	Hour o m. While Not While foctory,	street, office bldg , etc.)
OR ATTENDING be retained by the Street of a School of be deed with the State lead with	21 certify that (1) this movine attended the acceased from No	ov. 6, 1967, to Nov. 6, 1967, that (1) (mot les
ATTEND etained CTOR: A should lift the S	sow the deceased alive an Nov 6, 19 67, and that de	eath accurred atM, from causes and an the date stated above
TA ST	220 SIGNATURE	3:35 PM 225 DAY'S GNED
moy be retained RAI DIRECTOR: A Page 3 should be filed with the	Claston C Ede MO	ATTENDING MED DIRECTOR DIRECTOR PHYS D'8 CLOVE 7
AL O	22c PHYSICIAN S	22d ADDRESS
RA me	NAME(Type) Antonio M. Rivera, M.D.	South RivMadCent., Edgewater, Md.
Page 4 may be retained by the hospital or ottending To FUNERAL DIRECTOR: After this certificate has been director, page 3 should be detached for use as the should be filed with the State Dept. of Health prior to	230 BUR AL, CREMATION. 236 DATE THEREOF 236 NAME OF CEMETERY OR CREM	MATORY . 23d (DCATION (City or Town) (County) (Stote)
- 5 - 4 V	BURNING 11-8-67 HILLORE	ST HUNAPOLIS MID
- 11/2	24 FUNERAL DIRECTOR (ADDRESS)	250 REC D BY REGISTRAR 256 REGISTRAR'S SIGNATURE
VR A15 (4) 25M 1/67	John M. Montor T stone (luncouts 14	CI DNOV 9 1967 Cleanles Judges

DED S DYALENT OF SIELS





MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 74807 CERTIFICATE OF DEATH 14569 requires that the death certificate be executed within 24 haurs after death funeral s 1 and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. COUNTY o. STATE **L COUNTY** MARYLAND ANNE ARIMDEI ANNE ARUNDET b CITY OR TOWN (if outside corporate limits. c LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate amits, write RURAL and give negrest fown) write RURAL and give negrest town) RURAL-GLEN BURNIE 4 DAYS RURAL-MILLERSVILLE d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e IS RESIDENCE ON A FARM? NO X NORTH ARUNDEL GENERAL HOSPITAL BOX 12 CECIL AVE. NAME OF Middle Last 4 DATE carbai DECEASED (Type or print) DEATH ADOT PH NOVEMBE! S SEX 6 COLOR OR RACE 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS. 7 MARRIED NEVER MARRIED B. DATE OF BIRTH last birthday) Months Dovs Hours WIDOWED DIVORCED MALE OCTOBER 3, 1895 10a USUAL OCCUPATION (Give kind of work done 12 CITIZEN OF WHAT 10b KIND OF BLSINESS OR 1). BIRTHPLACE (County & State, or foreign country) during most of working life, even if retired) COUNTRY? **INDUSTRY** POLT CEMAN

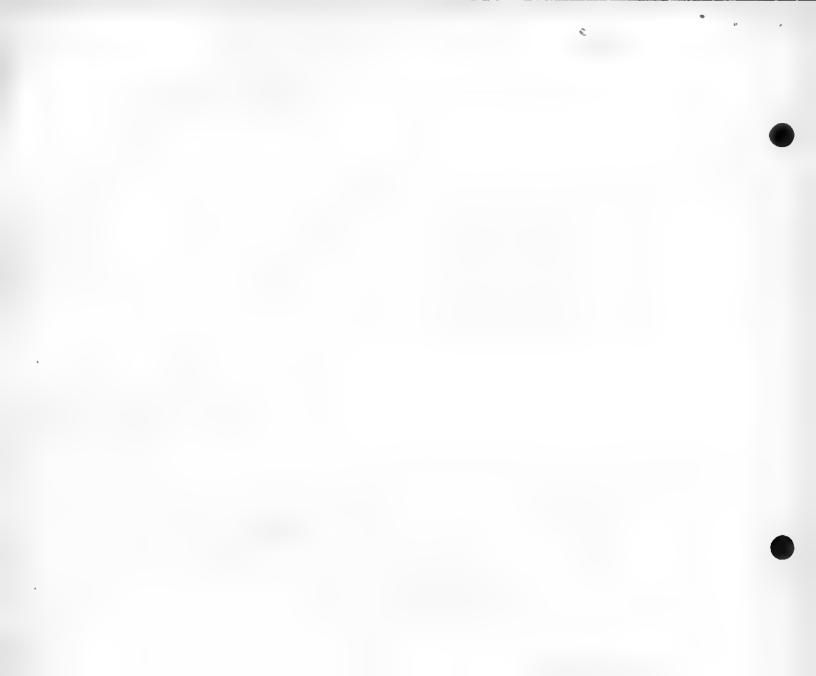
13. FATHER'S NAME BALTIMORE, MARYLAND

14 MOTHER'S MAIDEN NAME LAW ENFORCEMENT TISA remayal, Charles William Dill Elizabeth Hefner attending (15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give wor or dates of service) Ö signed by the atten burial-transit permi burial, cremation, o ves DILL CAUSE OF DEATH (Enter only one couse per line for (o), (b). NTERVAL BETWEEN ONSET AND DEATH PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gove rise to immediate couse (a). DUE TO stoting the underlying couse ₽ WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) YES TO NO O FUNERAL DIRECTOM: After this certificate 20o ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port 1 or Port II of item 18.) the hospital OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (State) Haur o.m. factory, street, office bldg., etc.) Not While at work ot work 196 / that (1) (we) last 21. I certify that (1) (this haspital) attended the deceased from shauld be retained 19 (-), and that death accurred at AM, from causes and on the date stated above. saw the deceased alive an. 22o. SIGNATURE 22b. DATE SIGNED MED DIRECTOR A director, page 3 M.D. PHYS 22d. ADDRESS 22c. PHYSICIAN'S SANTOS NAME (Type) 230 BUR AL, CREMATION 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) Cedar Hill Cemeter v Brooklyn Md2So REC'D BY REGISTRAR 2Sb REGISTRAR'S SIGNATURE Hopping . Hopping Funeral Home = Annapolis DATE NOV



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 3089F 14610 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) PLACE OF DEATH O. COUNTY A. A. CO . b COUNTY AAGO o STATE Page b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 9/en /Survice d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e IS RESIDENCI d. STREET ADDRESS ON A FARM? 7215 July Kd. YES NO [8. Give Pages This certificate should be executed within 24 hours after death NAME OF DATE Month Doy Year DECEASED OF DEATH LONARdo (Type or print) IF UNDER 1 YEAR 9 AGE (In years S SEX 7 MARR ED NEVER MARRIED 8 DATE OF B.RTH lost birthday) Months DIVORCED W DOWED 100 USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT COUNTRY? during most of working life, even if retired) New YORK USA PROduction WAS DECEASED EVER IN U.S. ARMED FORCES? 6 SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give wor or dates of service) any event within 103-20-7559 MRS GLORIE NTERVA. BETWEEN CAUSE OF DEATH (Enter only one couse per ONSET AND DEATH DEATH WAS CAUSED BY IMMEDIATE CAUSE (6) DUE TO Conditions, if any, which gave rise to immediate couse (a), DUE TO storing the underlying couse 19 WAS AUTOPS ar remayal, PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1.01 PERFORMED? NO DO 200 EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of term 181) PRIMARY Or CONTRIBUTING CAUSE OF DEATH 20c TIME OF NURY Month, Day Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home form 20f (City or Town) Hour om. foctory, street, office bldg , etc.) Not While at work of work 21 I certify that I took charge of the remains described above, held an Autopsy . Inspection deoth resulted from Noturol couses . Accident . Suicide . Homicide Undetermined monner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE the funeral FUNERAL DEPUTY MEDICAL EXAMINER LINGARUT W.Jy Address (Street city town, or county) NAME Type) 23¢ NAME OF CEMPTERY OR CREMATORY O BURIA CREMATION 0 Saltimore National VR A 15ME

MARYLAND STATE DEPARTMENT OF HEALTH



14803 PLACE OF DEATH O COUNTY ANNE ARUNDEL b CITY OR TOWN (If autside corporate mits, KIMBROUGH ARMY HOSPITAL NAME OF DECEASED (Type or print) MALE 13. FATHER'S NAME ELISHA DOCKERY 1S WAS DECEASED EVER IN U.S. ARMED FORCES?

6 COLOR OR RACE CAU 10a US_AL OCCUPATION (Give kind of work done during the property of the pro

PART I DEATH WAS CAUSED BY

17 INFORMANT

NANCY WADDELL

Address SAME AS # 2d/c VIRGINIA DOCKERY(W) CAUSED BY MASSIVE BILATERAL PULMONARY EMBOLISM

INTERVAL BETWEEN OWSET AND DEATH

30 Min

19 WAS AUTOPS' PERFORMED?

YES NO

Conditions, if any, which gave rise to immediate cause (a). stating the underlying couse

(b) DUE TO

DUE TO

18. CAUSE OF DEATH (Enter on y one couse per line for (a), (b), and (c))

(c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)

20b DESCR BE HOW INJURY OCCURRED (Enter nature of injury in Part or Part II of item 18.)

Nat While

2Dd NILIRY OCCURRED

16 SOCIAL SECURITY NO

218-22-9200

2De PLACE OF INJURY (Hame, farm, factory, street, office bldg, etc.

(C ty ar town)

(Caunty)

(Stote) 167_, ta21_Nov_67_, 19___, that (I) (Me) last

2) I certify that (I) (this kospidal) attended the deceased from 7 Nov.

saw the deceased alive an 21 Nov 67 22a, SIGNATURE

2Dg ACCIDENT WAS UNDERLYING [1] OR CONTRIBUTING [CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

2Dc TIME OF N. RY Manth, Day, Year Hauriam.

> , and that death accurred at 7:55M, from causes and on the date stated above. FREDERICK,

RIMBROUGH AH FT GEO G MEADE, MD

22b DATE SIGNED 21 NOV 8%

(County)

23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY REMOVAL (Specify) Glen Haven Memorial Pk. Glen Burnie, Maryland 2So REC'D BY REGISTRAR

Poge 4 moy be retoined director, page 3 should should be filed with the O FUNERAL 25M 1/67

The law requires that the death certificate be executed within 24 hours ofter death.

and in any event, within 72

or remayo

os the priar to

Stote Dept. of Health

certificate

attending physicion sermit. Then please

230 BURIAL CREMATION 24 FUNERAL DIRECTOR

Singleton Funeral Glen Burnie, Maryland

23d LOCATION (City or Town)

2Sb REGISTRAR'S SIGNATURE





MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14813 14805 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEP USUAL RESIDENCE (Where deceased lived, it institution. Residence before pumpision) PLACE OF DEATE o COUNTY n STATE b. COUNTY 3 to Page MARYLAND c. LENGTH OF STAY IN 16 TOWN (flours de corporate lim ts OWN (If autside carparate limits write RURAL and give nearest town) pup If not in hospita, give street address. e IS RES DENCE ON A FARM? in Item 18. Give Pages YES NO D after death rd "pending" in pencil in Item 18. Give Pag Chief Medical Examiners Office along with 3 NAME OF DATE Midd 8 Year DECEASED DEATH pages 1 and 2 with AGE (In years IF UNDER'T YEAR NEVER MARRIED asy upihday) Months Davs Hours and in any event within 72 haurs after death. WIDOWED DIVORCED USUAL OCC. PATION (GIV 11.-BIRTHPLACE (State ZEN OF WHAT 13 FATHER STNAME 14 MOTHER'S MAIDEN NAME permit. File 15 -WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO INFORMANI (Yes, no opunicawn) (If yes give war or dates of service INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line for (g), (b), and (c).) DISET AND DEATH PART I DEATH WAS CAUSED BY-IMMEDIATE (AUSE (a) e, writing the ward farwarded to the Ch DUE TO Conditions, if any, which gave (b) rise to immediate cause (a). DUE TO stating the underlying cause last PART II OTHER'S GNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAU DISEASE CONDITION GIVEN IN PART I(g) 19 WAS AUTOPSY remaval, PERFORMED? please execute the certificate, NO" YES be 20g EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 1 of Item 18.) 3 shauld 0 PRIMARY CONTRIBUTING MEDICAL EXAMINER: CAUSE OF DEATH cremation, 20c T ME OF NJURY Month, Day, Year 20e PLACE OF INJURY (Home, form (City or fown) (County (State) Hour o.m. Not While factory, street, office bldg., etc.) DIRECTOR: Page at wark described above held an Autapsy Inspection 1 21. I certify that L Inquiry 7 charge of the remains and in my apinion death resulted from Matura Causes Accident Suic de Hamicide Undetermined manner be retained CHIEF MEDICAL EXAMINER pr or ta ACTUAL 22 DATE SIGNED ASSISTANT MEDICAL EXAMINER may be re FUNERAL I SIGNATURE DEPUTY MEDICAL EXAMINER **EXAMINER'S** NAME 'Type: Address (Street, city, tawn or caunty) 23b DATE THEREOF 0 2Sa REC D By REG STRAR VR A15ME (5) C 6M 1767



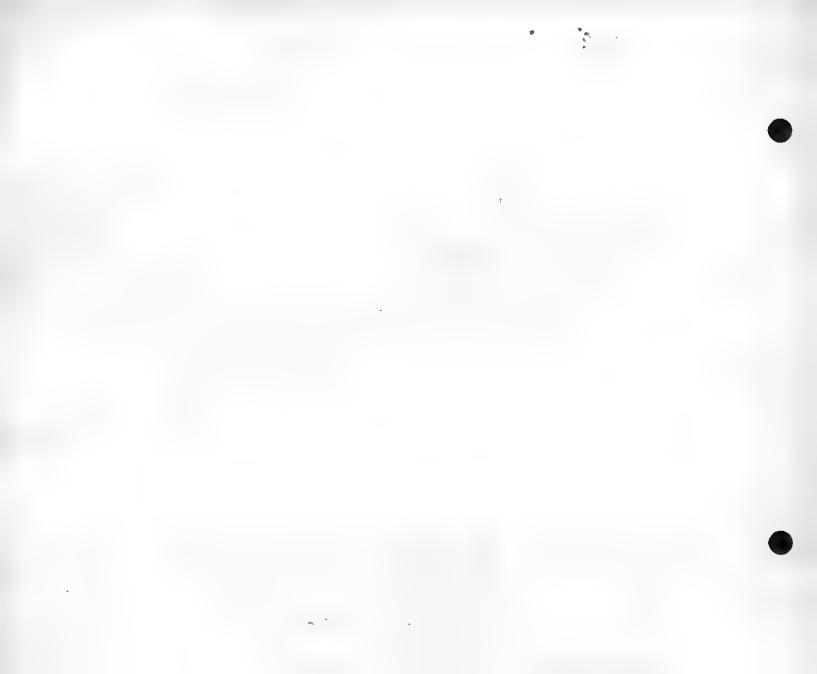
_	14805 CERTIFICATE OF DE	ATH	1481
1.		IDENCE (Where deceased lived, if Institute	on Res dence before
_	Anne Arundel Maryland Ma	ryland 5. COUNTY An DWN (If outside corporate limits, write RURA)	ne Arund
		en Burnie	e. fS
3.	North Arundel Convalescent Home 20 NAME OF First Middle 20 Lost	4 Carroll Road 4 Date Month	YES Dey Ye
	(Type or print) WALTER DOUGLAS DORSEY	DEATH 11	18 19
5.	SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH	9. AGE (In years IF UNE	ER TYEAR IF JND
	Male White WIDOWED □ DIVORCED □ 3/25/1	902 (ast birthdey) Month	b Deys Hours
10	De. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY: 11. BIRTHPLACE		CITIZEN OF WHAT
4	Assemblyman Electronics Dorse	y. Maryland	U. S. A
13.	D. FATHER'S NAME		
	Walter Dorsey Unkno	wn	
15.	. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17 INFORMANT	Address	
(4)	(es, ne, or unkown) (liyasgive weror dates of service) 218-99-7756 Vera H. D	orsev 204 Carro	11 Road
=	18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), end (c).]		INTERVAL E
	PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (6) acute cohowany	thingmasser	ONSET AN
		resclination.	2.3.
	Conditions, if any, which (b)		
	gove rise to immediate ceuse		
	(e), stelling the underlying Couse last.		
Z	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE	TERMINAL DISEASE CONDITION GIVEN IN	
ATIO	(6) middle ceretarl throm.	Been	PER YES [
CERTIFIC,	200. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of in	dury In Pert I or Part II of item 18.]	
CER	OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		
TY.	20c, TIME OF INJURY Month, Day, Yeer 20d, INJURY OCCURRED , 20e, PLACE OF INJURY (Hom	a, ferm, ; 20f. (City or town)	(County)
MEDICAL	Hour e.m. While Not While fectory, street, office bld	g., atc.)	
2		1967, 10 MOV. 18.	10/-7 that (1)
	10.400/.10.17		
	saw the deceased alive on U.V. //	av. 16 m. me causes and of	/ /2:
	L. C. de Augman' M.D. ATTENDING PHYS.	MED. STAFF DIRECTOR PHYS.	11/18/1
	22c. PHYSICIAN'S 22d. ADDRES.		1/10/01
	NAME (Type)	ospital Drive Gle	en Burni
23	B. BURIAL, CREMATION, 23b. DATE THEREOF 23c, NAME OF CEMETERY OR CREMATORY	23d, LOCATION (City, town or c	
***	REMOVAL (Specify)	y Glen Burnie,	МА
	Burial 11/20/67 Glen Haven Cemeter FUNERAL DIRECTOR'S SIGNATURE ADDRESS 25	B. REGISTRAR 256. REGISTRA	
	Raymond C. Fink Glen Burnie, Md.		carelas luo
l £			



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 74807 14515 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after deoth PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. COUNTY o. STATE **b** COUNTY Anne Arundel Maryland Anne Arundel MARYLAND. b (ITY OR TOWN (If outside corporate emits, write RURAL and give nearest town)
Annapol is c LENGTH OF STAY IN 1b. c CITY OR TOWN (if outside corporate mits, write RURAL and give nearest town) Annapolis d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e IS RESIDENCE ON A FARM? d STREET ADDRESS Anne Arundel General Hospital 63 Solomons Island Rd. YES NO DE NAME OF 4 DATE Lost Year DECEASED signed by the ottending physician and complete burial-transit permit. Then please remove carb burial, cremation, or remaval, and in any event, (Type or print) Clarence DOUGLAS 29 DEATH November 19 67 6 COLOR OR RACE 8. DATE OF BIRTH 9. AGE (n years F UNDER 1 YEAR F UNDER 24 HRS 7 MARRIED NEVER MARRIED last bailtailary) Months Doys Hours WIDOWED 🔀 June 25, 1909 DIVORCED Male Negro 100 US_AL OCCUPATION (Give kind of work done 10bc.K NO OF 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT COUNTRY? North Carolina 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT (Yes, no er upknown) (If yes give wor or dates of service) CAUSE OF DEATH (Enter only one couse per line for (a), PART I. DEATH WAS CAUSED BY INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (6) DUE TO Conditions, if any which gove nse to immediate cause (a). DUE TO stoting the underlying couse last. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE COND T ON GIVEN IN PART (6) WAS AUTOPSY PERFORMED? YES X NO certificate 200 ACCIDENT WAS UNDERLYING . 20b, DESCRIBE HOW INJURY OCCURRED (Enter noture of niury in Port I or Port II of item 181) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20¢ TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home form 20f (City or town) O FUNERAL DIRECTOR: After this foctory, street, office b dg , etc) Not While OR ATTENDING ot work at work 21. I certify that (1) (this haspital) attended the deceased fram 100 27 Nov 29, 1967, that (i) (we) last saw the deceased alive an. 196 I, and that death accurred at M, from causes and an the date stated above. 220 SIGNATURE 22b DATE SIGNED MED DIRECTOR ATTENDING PHYS. MD PHYS. 22d. AØDRESS TO HOSPITAL 22c PHYSICIAN'S NAME (Type) 23c NAME OF CEMETERY OR CREMATOR 230. BURIAL CREMATION LOCATION [City or Jown] REMOVAL (Specify) 25b. REGISTRAR'S SIGNATURE VR A15 (4) DATE



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14616 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1 PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased fived if institution Residence before admission) b. COUNTY o. COUNTY o. STATE AACO. Page A. A.Co. nent af MARY, AND b CITY OR TOWN (flourside corporate limits C. LENGTH OF STAY IN 16 c, C TY QR_JOWN (If outside corporate imits write RURAL and give nearest tawn) write RURAL and give negrest town? VISade 1117 d NAME OF HOSP TAL OR INSTITCTION (I not in hospital give street oddress) Depar e IS RESIDENCE d STREET ADDRESS ON A FARM? ARUNDEL - Hospital DOM-Worth YES □ NO.⊅ in Item 18. Give Pages snauld be farwarded to the Chief Medical Examiner's Office along with 3 NAME OF Year DECEASED EcKeRT 19 6 LERNON. DEATH (Type or print) 9 AGE (In years F UNDER 1 YEAR IF UNDER 24 HRS le pages land 2 with S SEX 7 MARRIED B OATE OF BRID 6 COLOR OR RACE MARR EO lost birthdoy) Months witnin 72 hours after death. WIOOWEO O VORCEO 60 yrs 10b, KINO OF BUSINESS OR 11 B RTHPLACE (State or foreign country) 12 CITIZEN OF WHAT 100 USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). NOUSTRY FLEC.CO MUREMAN 14 MOTHER'S MAIREN NAME 13 FATHER S NAME (Yes, no, or unknown) (If yes a ve wor or dates of service) TOSADENA 212-05-7055 MARIE FEKER NONE 1B. CAUSE OF DEATH (Enter only one couse per line for (#) INTERVAL BETWEEN ONSET AND GEATH PART I OFATH WAS CAUSED BY any event IMMEDIATE CAUSE (O' This certificate shauld OUE TO Conditions, if any, which gove (b) use to immediate couse (o). DUE TO stoting the underlying couse 19 WAS AUTOPS) PERFORMED? pe nsed PART II OTHER'S GNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) or removal, CERTIF CATION NO 5 200 EXTERNAL CAUSE WAS 20b OESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of Item 18) 3 should PRIMARY Cor CONTRIBUTING CAUSE OF DEATH 20d INJURY OCCURRED 20e PLACE OF INJURY (Home form 201 (City or town) (Stole) 20c TIME OF INJURY Month, Ooy, Year foctory, street office bldg etc.) Not While of work of work 2]. I certify that I taok charge of the remains described above, held an Autapsy Inspection 12. and in my apinian death resulted from Natural causes X. Accident Suicide . Ham cide Undetermined manner funeral director CHIEF MEDICAL EXAMINER 22. DATE SIGNED ASSISTANT MED CAL EXAMINER SIGNATURE OFPUTY MEDICAL EXAMINER **EXAMINER'S** Address (Street city town or county) NAME Typel the. 23c B RIAL CREMATION 23c NAME OF CEMETERY OR CREMATOR 0 25b REGISTRAR . SIGNATUR 250 RECOBY REGISTRAR VR ATSME 6M 1 67



MARYLAND STATE DEPARTMENT OF HEALTH 14517 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 < 4808 CERTIFICATE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) Anne Arundel Anne Arundel Triaryland MARYLAND c CITY OR TOWN (If auts de corporate limits, write RURAL and give necrest town) b CITY OR TOWN (If outside corporate limits, e. LENGTH OF STAY (N. 16 write RURAL and give nearest town) Arnold d. STREET ADDRESS e IS RES DENCE d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, a ve street address) General Hospital Anne Arundel Rt. #3 Box 368 YES ₩0 [Lost 4. DATE Month Doy Year OF doar 67 19 DEATH DATE OF BIRTH 9 AGE (In years IF UNDER 1 YEAR IF UNDER 24 HRS 7. MARRIED 4 NEVER MARRIED 7 ast birthday) Months Dovs Haurs 4-25-96 WIDOWED DIVORCED 106 KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 10a USUAL OCCUPATION (Give kind of work done 12 CT ZEN OF WHAT during most of working the even if retired) INDUSTRY Balto., Md. 14. MOTHER'S MAIDEN NAME Sarah Wallace Frank Foreman 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANT 16 SOCIAL SECURITY NO (Yes, no ar unknown) (If yes give war or dates of service) Calvin H. Edgar, Rt.#3 Box 368 Arnold, Md. None 18 CAUSE OF DEATH (Enter only one cause per line fag(a), (b), and (c).) INTERVAL BETWEEN PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUE TO DUE TO WAS AUTOPSY PART TO OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION G VEN IN PART 1(a) PERFORMED? 20b. DESGRIBE HOW INJURY OCCURRED. (Enter not tree of injury up Part I ar Part II of item 18 20e PLACE OF INJRY (Hame, farm, 20d INJURY OCCURRED (C y or town) (County) (Stote) factory, street, affice blda., etc.) Not While

200 X Canditians, if any, which gave rise to immediate cause (o), stating the underlying cause ACCIDENT WAS UNDERLYING L OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. TIME OF INJURY Manth, Day, Year Haur a.m.

PHYSICIAN'S

NAME (Type)

24 FUNERAL DIRECTOR

). PLACE OF DEATH

a. COUNTY

NAME OF

DECEASED (Type or print)

temale

13 FATHER'S NAME

21. I certify that (1) (this haspital) attended the deceased from

trankl

ATTENDING

PHYS

22d ADDRESS

, and that death accurred at 1010 from causes and an the date stated above 22b DATE SIGNED

(State)

PHYS Annapolis

(County)

230 BURIAL, CREMATION 23b. DATE THEREOF 11-15-67

saw the deceased alive an_

Beck

ADDRESS

23c NAME OF CEMETERY OR CREMATORY Parkwood

M D

23d LOCATION (City or Town) Balto., Md. 25g REC'D BY REGISTRAR

DIRECTOR

VR A15 (4) 25M 1/67

The law requires that the death certificate be executed within 24 hours after death

remove corban

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and in ony event,

burial, cremotion, or removal,

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age 3 should be detached for use as the filed with the State Dept. of Health prior to

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this certificate

O FUNERAL DIRECTOR:

O HOSPITAL OR ATTENDING PHYSICIAN: The low re Page 4 may be retained by the haspital or attending

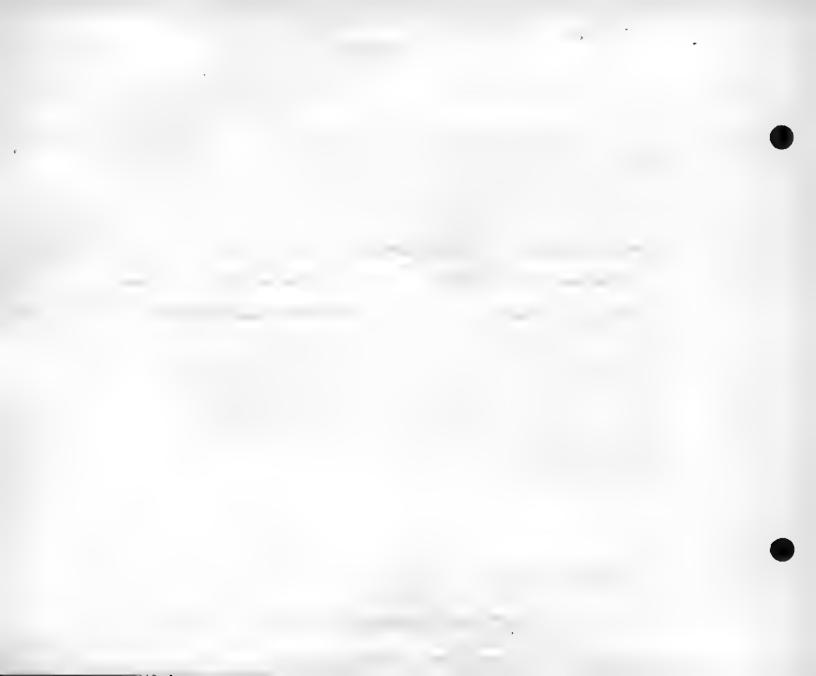
Leonard J. Ruck, Inc., 5305 Harford Rd.

dward

25b REGISTRAR'S SIGNATURE Millanely Judge



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14810 14618 CERTIFICATE OF DEATH I. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, funst fution: Residence before admission o. COUNTY MARYLAND b CITY OR TOWN (f autside carparate limits, C LENGTH OF STAY IN 16 rite RURAL and give nearest town) requires that the death certificate be executed within 24 haurs d NAME OF HOSPITA. OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS S RESIDENCE ON A FARM? NAME OF DATE Year DECEASED OF LOLA November icate has been signed by the attending physician and complete far use as the burial-transit permit. Then please remove carb Health priar to burial, crematian, ar remaval, and in any event, (Type of pnnt) RENCE DEATH 5 SEX 9 AGE (In years IF UNDER 1 YEAR 6. COLOR OR RACE NEVER MARRIED IF UNDER 24 HRS last birthday) WIDOWED DIVORCED 10a USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12 CIT ZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? Home maker Home 13. FATHER'S NAM 1S WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17. INFORMAN (Yes, no, ar unknown) (If yes give war ar dates af service) 18 CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c). INTERVAL BETWEEN ONSET AND PEATH DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUE TO Candinians if any, which gave rise to immediate cause (a), **DUE TO** stating the underlying cause PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBLING TO DEATH BUT NOT REVATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) WAS ALTOPS PERFORMED? NO P 200 ACCIDENT WAS UNDERLYING [1] 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Part 1 of Port II of Jern 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF N.URY Month, Day, Year 20d INJURY OCCURRED 20e, PLACE OF NJURY (Hame, farm, (City or town) (State) Haur a.m. foctory, street, affice bidg, etc.) Not While ATTENDING at wark O FUNERAL DIRECTOR: After 21. I certify that (1) (this haspital) attended the deceased from , and that death occurred at saw the deceased alive an fram causes and an the date stated above 22a, SIGNATURE ATTENDING director, page 3 shauld be filed v MD DIRECTOR 22c. PHYSICIAN S 22d. ADDRESS O HOSPITAL Page 4 may NAME (Type) 230 BUR AL, CREMAT ON 23b DATE THEREOF OR CREMATORY 23d LOCATION (County) REMOVAL (Specify) Cem, VR A15 (4)



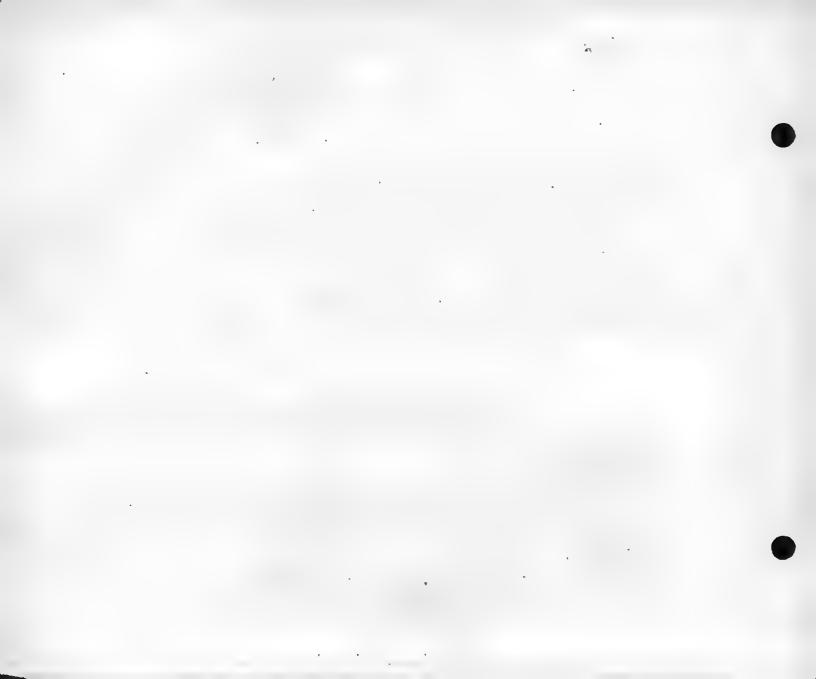
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 77.811 CERTIFICATE OF DEATH 14819 The law requires that the death certificate be executed within 24 hours after death. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o. COUNTI b. COUNTY MARYLAND b CITY OR TOWN (If outside comparate limits. c LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate Amits, write RURAL and give nearest town) withe RURAL and give nearest town win d NAME OF HOSPITAL OR INSTITUTION (If pot in haspital, give, street address) d. STREET ADDRESS ON A FARM? NO NAME OF 4 DATE Year DECEASED (Type or print) DEATH F UNDER 1 YEAR S SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED DATE OF BIRTH AGE (n years IF UNDER 24 HRS lost buttiday) Months W WIDOWED DIVORCED 10a USUAL OCCUPATION (Give kind of work done during most of working life, even 'f retired) 10b KIND OF BUSINESS OR 12. CITIZEN OF WHAT 11 BIRTHPLACE (County & State or foreign country) COUNTRY? of Education attending physician permit. Then please Fairmount, Md. ret- Jahitor 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME buria, crematian, ar removal, unknown 1081 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17. INFORMANT Address (Yes, na, or unknown) (If yes give war or dates of service) John Ford, son, 4013 Biddison Lane 3-16-3549 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c),) INTERVAL BETWEEN burial-transit PART I DEATH WAS CALSED BY ONSET AND DEATH IMMEDIATE CAUSE (a) **O HOSPITAL OR ATTENDING PHYSICIAN:** The law requires the Page 4 may be retained by the haspital ar attending physician. **DUE TO** Conditions, if ony, which gove rise to immediate cause (a). DUF TO stoting the underlying couse d far use as the af Health priar ta last PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART ((0) 19 WAS AUTOPSY PERFORMED? 200 ACC DENT WAS UNDERLYING 20b DESCRIBE HOW NULLY OCCURRED (Enter nature of injury in Port or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) Hour ' a.m factory, street, office bldg, etc.) of work 19 52 ta (1-18 19 5/that (1) (we) last 21. I certify that (I) (this haspital) attended the deceased from 12-15 director, page 3 should should be filed with the 1967, and that death accurred at 1000 M, from causes and an the date stated above. saw the deceased alive an \ O FUNERAL DIRECTOR: 220 SIGNATURE 22b DATE SIGNED ATTENDING M.D. 22d ADDRESS CROWNES 23c NAME OF CEMETERY OR CREMATORY 23o BURIAL, CREMATION. 23b DATE THEREOF 23d LOCATION (City or Town) (County) REMOVAL (Specify) 11/22/67 Gardens of Faith Baltimore, Md. 24 FUNERAL DIRECTOR
Schimunek Funeral Home, Inc.
3331 Brehms Lane 2Su REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A15 (4) 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W PRESTON STREET, BALTIMORE, MARYLAND 21201 14820 14812 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEP PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. COLNIY Anne Arundel o. STATE Maryland b. COUNTY 3 to Page deloy is MARYLAND Anne Arundel Départmen b. CITY OR TOWN (If outside corporate limits, c LENGTH OF STAY IN 1b. c. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) ond write RURAL and give negrest town) P.M3 Tessun d NAME OF HOSPITA, OR INSTITUTION (If not in haspita, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? form House of Correction in Item 18. Give Poges r's Office along with for Ridge Road YES NO the Stote be executed within 24 hours after death NAME OF Middle First DATE Doy Year DECEASED EDWARD (Type or print) FORREST DEATH November DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR S SEX 6. COLOR OR RACE IF UNDER 24 HRS 7. MARRIED NEVER MARRIED lost birthdoy) Months Doys Male White WIDOWED DIVORCED 52 yrs after deoth 9/10/1915 ond 2 10a USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired)
CORRECTIONAL OFFICER INDUSTRY USA COLNTRY ? NEW YORK STATE OF MD. Exom ner's 13 FATHER'S NAME mencil 14. MOTHER'S MAIDEN NAME hours CHARLES FORREST LOUISE BASTIAN Œ 17 INFORMANT IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO Address t permit. w thin 72 (Yes, no, or unknown) (If yes a ve war or dotes of service) 16/28/35 2/28/57 611 468 17 MRS MARTHA P. FORREST - RIDGE MARYLAND Chief Med INTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c), ONSET AND DEATH PART I. DEATH WAS CAUSED BY event Arteriosclerotic Cardiovascular Disease IMMEDIATE CAUSE (o) word This certificate should DUE TO buriol dny Conditions, if any, which gove (b) rise to immediate cause (a). , ⊑ **DUE TO** stoling the underlying couse e, writing the forwarded to 0 puo iast S remova, PART JOTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 160. WAS AUTOPSY PERFORMED? CERTIFICATION the certificote, YES -NO 20o EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port L or Port 1 of item 1B.) 3 should Ö PRIMARY Or CONTRIBUTING O should EXAMINER: CAUSE OF DEATH MEDICAL 20c. TIME OF NURY Month, Doy Year 20e PLACE OF INJURY (Home form 20f (City pritown) 20d NJURY OCCURRED (County) (State) Hour o.m. factory, street, office bldg., etc.) Not While moy be retoined for your FUNERAL DIRECTOR: Poge of work at work please execute 21 I certify that a tack charge of the remains described above, held an Autapsy [X] Inspection lngu ry and in my apinian buriol, Notural causes X death resulted from: Accident Suicide Undetermined manner funeral director CHIEF MEDICAL EXAMINER ACTUA 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER XX prior SIGNATURE DEPUTY U.(Spitz, DEPUTY MEDICAL EXAMINER 11/18/67 Werner **EXAMINER'S** Heofth NAME (Type) Address (Street, city, town, or county) 236 DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY BURIAL CREMATION 23d LOCATION (City or Town) (County) 9 REMOVAL (Specify) ARLINGTON NATL. CEM. ARLINGTON VA. 25b. REGISTRAR'S SIGNATURE **ADDRESS** 2So. REC'D BY REGISTRAR VR A15ME (5) 6M 1/67 WELCH - LEONARDTOWN.MD.



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201/2 1/2 2 1 1481 CERTIFICATE OF DEATH 24 haurs after death 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) 1. PLACE OF DEATH County o. COUNTY D. STATE MARYLAND CARAGTH OF STAY IN 16 (If outside corporate limits, Expits write RURAL and give nearest town) write RURAL ond give neorest town) d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) IS RESIDENCE ON A FARM? NO X requires that the death certificate be executed within NAME OF E est Middle OF DECEASED DEATH (Type or print) S SEX DATE OF BIRTH 6 COLOR OR RACE 7 MARRIED 风 NEVER MARRIED AGE (In years lost birthdoy) Months Doys Hours WIDOWED DIVORCED IOb. KIND OF BUSINESS OR 100 USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & Stote, or foreign country) 12 CITIZEN OF WHAT during most of work no life even if retired) INDUSTRY COUNTRY? please FINLAND 13. FATHER'S NAME 14. MOTHERS MAIDEN NAME eu JUSSI JOHN SALONEN UNKNOWN IS. WAS DECEASED EVER IN ... S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT Address State (Yes, no or unknown) (If yes give war or dotes of service) INTERVAL BETWEEN 1B. CAUSE OF DEATH (Enter only one couse per line for (o), (b) and (c)) ONSET AND DEATH burial-transit PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (6) signed by DUE TO Conditions, if ony, which gove rise to immediate couse (a). DUE TO stating the underlying couse TO FUNERAL DIRECTOR: After this certificate has been the last WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) detached far use te Dept. af Kealth NO YES 205 DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port II of item 18.) 200 ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL (20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (Stote) TIME OF INJURY Month, Doy, Year Hour am. foctory, street, office bldg., etc.) Not While ot work 21. I certify that (1) (this hospital) attended the deceased from 10/22 19.6 7that (1) (we) last 19 6 / ta 19.67, and that death accurred at 4.20 M, from causes and an the date stated above. saw the deceased alive on, 22a SIGNATURE 卤 M.D. PHYS DIRECTOR ADDRESS 22d PHYSICIAN S NAME (Type) directar, 230. BUR.AL, CREMAT ON, 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. ¿OCATION (City or Town) (County) (Stote) BENDEMY (Secrety) 11/27/67 Oak Lawn Cemetery Baltimore Maryland 25b. REGISTRAR S SIGNATURE ADDRESS 2SO REC D BY REGISTRAR SANDER & VR A15 (4) SONS INC. BALTO. 20 M 1/66



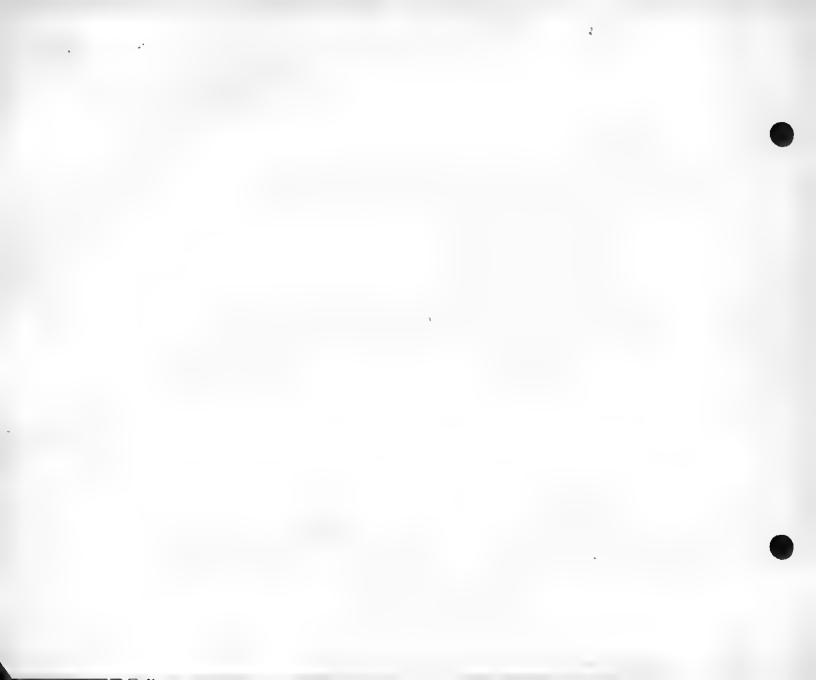
MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14814 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1. PLACE OF DEATH USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY b COUNTY MACO MARYLAND b CTY OR TOWN (flourside corporate limits.) CLENGTH OF STAY IN 16 c CITY OR TOWN (if outside corporate limits write RURA), and give nearest town) wate RURAL and give nearest town) Brook/41 - 21225 100 BURULE d. NAME OF HOSPITAL OR INSTITUTION (finor in hospital give street oddress) d STREET ADDRESS e IS RESIDENCE ON A FARM? De e Statel Del 72 hours in Item 18. Give Pages 1, r's Office along with farm 208 FRANKLIN - AVE YES NO 🖂 be executed within 24 haurs after death 3 NAME OF Lost 4 DATE DECEASED with the within 73 TORTSON NOV (Type or print) DEATH 19 6 5 SEX 6. COLOR OR RACE DATE OF B RTH 9 AGE (In years IF UNDER 1 YEAR NEVER MARR ED 50st birthday) Feb 3.1908 W-DOWED | DIVORCED event 1Do US_AL OCCUPATION (Give kind of work done 1Db KIND OF BUSINESS OR 11 BIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT USA TRY ? during must of working bloover if retired) INDUSTRY Md 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME Walter L Hall Frederica Myers pup IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT (Yes, no re unknown) (If yes give wor or dates of service) or removal, 214-46-0595 Family Same NTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b) and (c). PART I. DEATH WAS CAUSED BY AND DEATH *MMEDIATE CAUSE (o) This certificate should crematian, DUE TO Conditions, if ony, which gove rise to immediate couse (a). DUE TO stoting the underlying couse used os burial, a 19 WAS AUTOPSY PERFORMED? PART II OTHER SIGN F CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 20o EXTERNAL CAUSE WAS 2Db DESCRIBE HOW INJURY OCCURRED (Enter noture of njury in Port I or Port I of tem 18.) PRIMARY CONTRIBUTING CAUSE OF DEATH 20c TIME OF INJURY Month, Day Year 2De PLACE OF INJURY (Home form 2Dd INJURY OCCURRED (City or town) (County) (Stote) Not While foctory, street, office bldg. etc.) may be retained for yaur FUNERAL DIRECTOR: Page of work ot work 21 I certify that I took charge of the remains described above, held on Autopsy Inspection [Inquiry and in my opinion death resulted from Notural couses Accident . Suicide . Homicide Undetermined monner CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE Health or DEPUTY MEDICAL EXAMINER EXAMINER'S NAME (Type) Address (Street, city, town, or county) BUR AL CREMATION 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) (Stote) * 0 REMOVAL (Specify) AA Co Glen Burnie Md REG STRAR S SIGNATURE

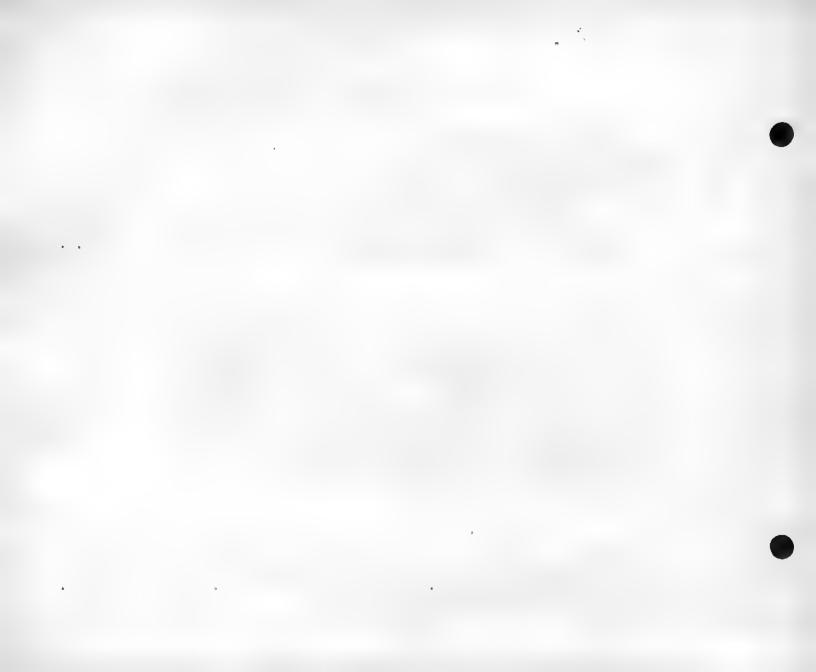


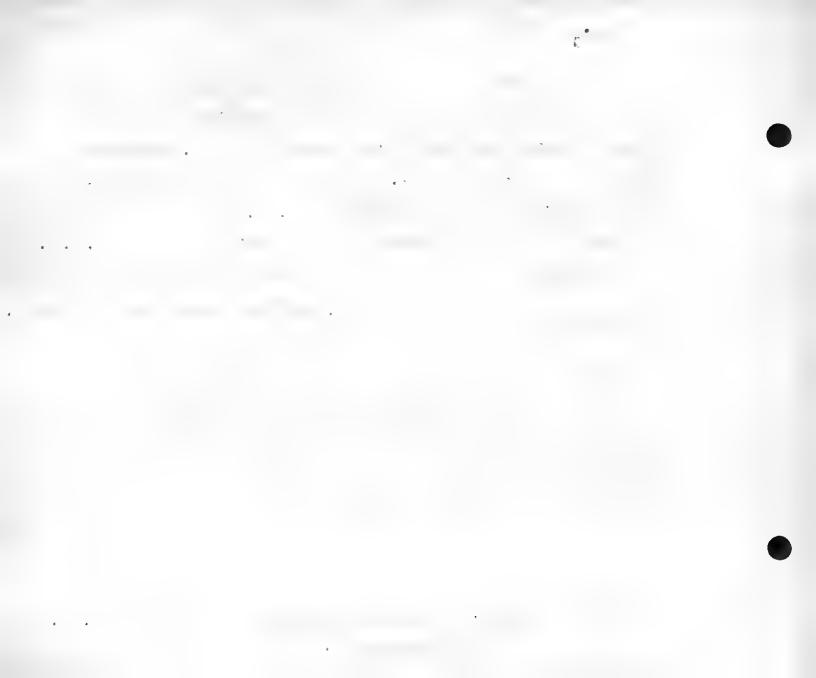
DIVISION OF STATISTICAL RESEARCH AND RECORDS. 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH should 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If Assistation: Residence before edmission) b. CITY OR TOWN (if outlide corporate lim to & LENGTH OF STAY IN 16 OR/TOWN (If putside corporate hmils, write RURAL and give nearest town) RURAL and give searest town) d. NAME OF BOSPITAL OR INSTITUTION .IF not in hospital, give street eddress) d. STREET ADDRESS IS RESIDENCE ON A FARM? YES NO SZ NAME OF Middle DECEASED (Type or print) DEATH 1960 AGE in years | IF UNDER 1 YEAR IF UNDER 24 HRS NEVER MARRIED last birthdeyl Months WIDOWED DIVORCED [For foreign country) 12. CITIZEN OF WHAT COUNTRY USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY done during most of working life, even if relired) Hone House wife 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMAN [Yes, no, or unknwn) | (Ifyes give we ror detes of service) 18. CAUSE OF DEATH Enter only one ceuse per line for (a) (b), end (c). INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) DUE TO Conditions, if eny, which geve rise to immediate cause DUE TO (a), slating the undarlying PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(+) 19. WAS AUTOPSY PERFORMED? 200. ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Port t or Port II of Item 18.) OR CONTRIBUTING CAUSE OF DEATH 20c. TIME OF INJURY Month, Dey, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, ferm, 20f. (City or town) (County) (Stete) fectory, street, office bldg., etc.) Not White DIA. Hour e.m. While 21. I certify that (1) (this hospital) attended the deceased from linguist 1967 to November, 1967, that (1) (we) last saw the deceased alive on The results 1619.67., and that death occurred at 3 PM, from the causes and on the date stated above. 22_e. SIGNATURE ATTENDING SIGNED X DIRECTOR 22d ADDRESS HOSPIA death. Pag. TO FUNERA director. 22c, PHYSICIAN'S NAME (Type 1705 EAST WEST HWY. SILVER SPRING WANDEZ 23d, JOCATION ICITY. BURIAL, CREMATION, 1 23b 25s. REC'D BY REGISTRAR 25s. REGISTRAR'S SIGNATURE TH FUNERAL DIRECTOR'S SIGNATURE



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14815 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) o COUNTY o STATE b COUNTY MARYLAND Melay c LENGTH OF STAY IN 1b c CITY OR TOWN b CITY OR TOWN (If outside corporate imits If autside corporate imits write RURAL and a ve nearest town) & NAME OF HOSPITA, OR INSTITUTION d STREET AODRESS B IS RESIDENCE ate De 134 NO in Item 18. Giva Pages This certificate shauld be executed within 24 hours after Teath alang with NAME OF Middle 4 DATE Lost Month Year DECEASED OF 1967 12057 (Type or print) DEATH S SEX AGE (In years IF JADER 1 YEAR IF UNDER 24 HRS 6 COLOR OR RACE 7 MARRIED NEVER MARRIED Jast birthday) Manths 41 haurs after death WIDOWED DIVORCED Office 100 USUAL OCCUPATION (Give kind of work dane Ob KIND OF BUSINESS OR 11 BIRTHPLACE (State or fore on country) 12 CITIZEN OF WHAT during most of working to, even if retired) UNDUSTRY 13 FATHER S NAME 14 MOTHER SMAIDEN NAME d) Crman Georg 20 17 INFORMANT S WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO Address the Chief Medical (Yes na, or unknown) (If yes give war or dates af service) w:fhin NTERVAL BETWEEN 1B CAUSE Of DEATH (Enter only one couse per one for (a) burial-transit ONSET AND DEATH event PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) wr ting the word DUE TO dny Conditions, if any, which gave nse ta immediate cause (a), farwarded ta DUF TO stating the underlying cause Ð. Si last used 19 WAS AUTOPSY remayal, PART II OTHER SIGNIFICANT COND TIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAL DISEASE CONDITION GIVEN IN PART (o) PERFORMED? CERTIFICATION the certificate, YES NO IZ þe 200 EXTERNAL CAUSE WAS PRIMARY () OF CONTRIBUTING 20b DESCRIBE HOW N. LRY OCCURRED (Enter nature of noury in Part I or Part II of tem 1B) 3 shauld Ы EXAMILLER: CAUSE OF DEATH cremation. MEDICAL 20d INJURY OCCURRED 20e PLACE OF NJURY (Mame, form 20f (City or lown) 20c I.ME OF INJURY Month, Day, Year Hour a.m. factory, street, affice bldg. etc.) VOUL Not While DIRECTOR: Page Diegs Execute nt work 21. I certify that Lited charge of the remains described above, held an Autopsy Inspection and in my apinian Ь death resulted from Natural causes Accident Suicide Hamicide Undetermined manner be retained CHIFF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER prior . SIGNATURE FINERAL DEPUTY MEDICAL EXAMINER **EXAMINER'S** Hea th NAME (Type) Address (Street, city town, or county) 23c NAME OF CEMETERY OR CREMATORY 230 BURIA CREMATION 0 MOVAL (Specify F.F. LINCOLN COMETEN FUNERAL DIRECTOR VR A 15ME (5) 6M 1/67







MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14827 CERTIFICATE OF DEATH PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, function Residence before admission) ON COUNTY b COUNTY MARYLAND b CITY OR TOWN (If outside corporate limits. c. LENGTH OF STAY IN 16 TOWN (If outside corporate limits, write RJRA) and give nearest town) write RURAL and give nearest town) 24 hours Baltimore Days BURNIE led in d. NAME OF HOSPITA. OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS IS RESIDENCE ON A FARM? NO Z The low requires that the death certificate be executed within NAME OF Middle 000 Month Day Year e DECEASED (Type or print) DEATH COL S. SEX 6 COLOR OR RACE 7. MARRIED DATE OF BIRTH AGE (n years IF UNDER 1 YEAR IF UNDER 24 HR NEVER MARRIED remove last birthday) Months Days ond in any DIVORCED 100. USJAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 12 CITIZEN OF WHAT 11. BIRTHPLACE (County & State, or foreign country) Retired, Foreman U. S. A. INDUSTRY physician American Can Co. Maryland 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME cremation, or removal, John Gnacyk Angela Daniel 17 INFORMANT (Daughter) 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO (Yes, no, orunknown) (If yes give wor or dotes of service) EssexAddrad. Rd. permit. 212-09-5082 A Mrs. Frances Swinder, 226 Back River Neck 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c) INTERVAL BETWEEN burial-tronsit ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) á DUE TO signed ! Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse of Health prior to 19 WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) YES T NO certificate 0 200 ACC DENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port 1 of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form (City or town) (Vtruo3) (Stote) Hour a.m. Not While factory, street, office bldg., etc.) of work L 21. I certify that (1) (this haspital) attended the deceased from WV. 27, 1967 to UN . 25 75 19 67, and that death accurred at 9.464 M, fram causes and on the date stated above DIRECTOR: saw the deceased glive an 220 SIGNATURE 22b DAJE SIGNED Irrector, page 3 hauld be filed v CLM. DIRECTOR 22d ADDRESS 22c. PHYSICIAN'S FUNERAL NAME (Type) 10 23b DATE THEREOF 11/29/67 230 BURIAL, CREMATION, 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (State) (County) REMOVAL (Specify)
Burial St. Stanislaus Cem. Baltimore, Md. 0 ᅙ 24 FUNERAL DIRECTOR ADDRESS. 250 RECD BY REGISTRAR John J. Duda, 2829 Hudson St. Balto. Md. 25M 1/67





MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 9/3/70 mcm 24 haurs after death. 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) 1. PLACE OF DEATH b. COUNTY o. COUNTY o STATE A.A.Co Maryland MARYLAND Anne Arundel c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 1b write RURAL and give pearest town) or remaval, and in any event, within 72-hauss Rural Annapolis 36 Annapolis (Kura] e IS RESIDENCE ON A FARM? d. STREET ADDRESS d NAME OF HOSPITAL OR INSTITUT ON (If not in hospital, give street address) the attending physician and campletely filled in sit permit. Then please remove carban papers Rt 3 BayRidge Rd Bx 155 NO TO Rt 3 BayRidge Road Bx 155 PHYSICIAN: The law requires that the death certificate be executed with: 3. NAME OF Middle Last Year Ferst DECEASED (Type or print) 1967 November 6 NMN Dewford DEATH FUNDER 1 YEAR IF UNDER 24 HRS S. SEX 9. AGE (In years NEVER MARRIED 8 DATE OF BIRTHT /22/17 7 MARRIED birthday) Months Days Hours JUIA 23 /1918 Male Negra WIDOWED DIVORCED 106 KIND OF BUSINESS OR 11. BIRTHPLACE (Caunty & State, or foreign country) 12 C TIZEN OF WHAT 100. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Presser (Cleaners A.A. Co. Md Presser 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAMI Elmira Parker Ruben Gray IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT Address permit. (Yes, no, or unknown) (If yes give wor or dotes of service) 216-12-8104 Augusta Gray Bx 155 Rt 3 Anna. Md No CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) signed by the burial-transit p burial, crematic PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) Page 4 may be retained by the hospital ar attending physician. DUE TO Conditions, if ony, which gove rise to immediate couse (o), DUE TO stating the underlying cause O FUNERAL DIRECTOR: After this certificate has been far use as the WAS AUTOPSY PART IF OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(c) PERFORMED? Health NO S 205 DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 200 ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) (County) (Stote) 20e, PLACE OF INJURY (Home, form, 20d INJURY OCCURRED 20c TIME OF INJURY Month, Doy, Year factory, street, office bldg., etc.) Not While ot work at work 1967, that (1) (we) last 21 I certify that (I) (this bospital) attended the deceased fram_ . 19 64. ta _1967, and that death occurred at 9:25 PM, from causes and an the date stated above saw the deceased alive an_ DATE SIGNED 220. SIGNATURE 22b ATTENDING PHYS DIRECTOR PHYS. director, page shauld be filed 22d. ADDRESS

Murrag 22c. PHYSICIAN'S NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23d EOCATION (City or Town) 23b DATE THEREOF (County) (Stote) 230 BURIAL CREMATION Burial (Specify) A.A.Co Md 11-10-67 Annapolis Neck Annapolis 2So. REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR Milanelas C.E. Hicks, 111 Annapolis, Maryland 20 M 1/60



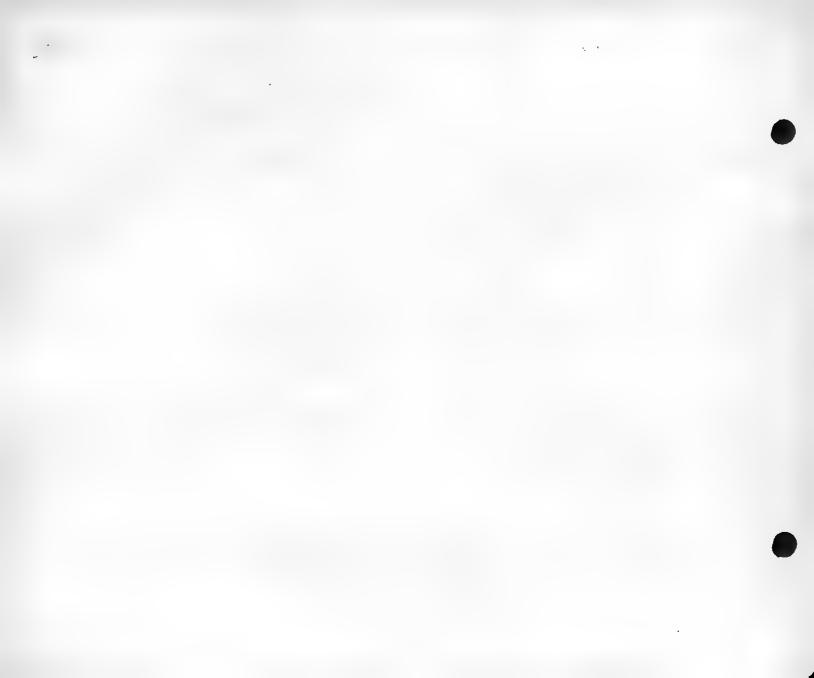
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14822 CERTIFICATE OF DEATH 14830 The law requires that the death certificate be executed within 24 hours after death death unerol 1 and PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o. COUNTY o. STATE b. COUNTY Maryland MARYLAND Anne Arundel Anne Arundel b. CITY OR TOWN (If autside carparate imits, write RURAL and give georest town) c CITY OR TOWN (If autside corporate imits, write RURA, and give nearest town) c LENGTH OF STAY IN 16 Annapolis Annapolis burial, cremation, or removal, and in any event, within 72 has e IS RES DENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS 317 West St.. Anne Arundel General Hospital NO CX YES 3 NAME OF physicion and completely fi en please remove corban First Middle 4. DATE Manth Last Day Year DECEASED GREENWELL November 19 67 Eliel Joseph (Type or pnnt) DEATH IF UNDER 1 YEAR F UNDER 24 HRS S SEX 6. COLOR OR RACE 7 MARRIED X X 8. DATE OF BIRTH AGE (In years NEVER MARRIED last birthdoy) Doys Hours April 28, 1893 Male White WIDOWED DIVORCED 10a USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? Maryland maintenance .ve. roads 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ottending phys Joseph T Roberta Turner 16. SOCIAL SECURITY NO. IS WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dates of service) 212-14-1749 Clara W. Greenwell INTERVAL BETWEEN ONSET AND DEATH 18 CAUSE OF DEATH (Enter only one cause per the for (a), (b), and (c) **burial-tronsit** PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) **TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires the Poge 4 may be retained by the hospitol or attending physicion. signed by 4231 DUE TO Conditions, if any, which gave rise to immediate cause (o), DUE TO stoting the underlying couse as the 19 WAS ALTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAL DISEASE CONDITION for use NO V YES certificote DESCRIBE HOW INJURY OCCURRED (Enter nature of Injury in Port I ar Part II of fem 18) 200 ACC DENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, farm (City or town) (County) (Stote) Hour 'a.m. Not While factory, street, office bldg., etc.) 1967, to Nov. 7 . 19_67 that () toa) lost 21 I certify that (I) (this hoppital) attended the deceased from_ says the deceased alive on Nov. 7 19 67, and that death occurred at M, from couses and on the date stated above. 2:00 AM SIGNAL IRE 22b DATE SIGNED STAFF director, poge 3 should be filed v DIRECTOR 22c PHYSICIAN S 22d ADDRESS FUNERAL NAME (Type) Maurice Klawans. M.D. 31 Southgate Ave., Annapolis, Md. 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23a. BURIAL CREMATION. (County) (Stote) REMOVAL (Specify) Hillcrest Cemeter 25g RECD BY REGISTRAR TOOL TO REGISTRAX S SIGNATURE 24. FUNERAL DIRECTOR Mariles Hopping Fun rul Andapolis, Md. Alu le



1	MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
	14823	CERTIFICATE OF DEATH	14831	
ours after deoth by the funeral Pages gradi	PLACE OF DEATH COUNTY Anne Arundel CITY OR TOWN (If autside carparate mils, write RURAL and give nearest town)	MARYLAND O. STATE MARYLAND C LENGTH OF STAY IN 16 C CITY OR TOWN (II	(Where deceosed Eved, if Institution Residence before admission) b. COUNTY Anne Arunde 1 outside corporate limits, write RURAL and give nearest tawn)	
tilled is by the property of t	Annapolis d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, g Anne Arundel Genera	ive street address) d. STREET ADDRESS	hnapolis, o is residence on A FARM? Hilltop Lane, Apt. 203 VES NO	
ompletely fill	3. NAME OF DECEASED (Type or print) S SEX 6. COLOR OR RACE 7 MARRIED	Marie GRYCTKO Marie GRYCTKO Mever Married B Date of Birth	4. DATE Month Day Year OF DEATH November 23 19 67 9 AGE (In years IF UNDER 1 YEAR IF JNDER 24 HRS last birthday) 1 Months Days Hours Man	
strificote be executed with physician and completely en please remove corbinosol, ond in ony event, ovol, ov			y & Stote, or foreign country) Pennsylvania 12. (ITIZEN OF WHAT COUNTRY? U. S.	
death certific ttending phys srmit. Then p n, or removol,	IS. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war ar dates af service)	ES FLORE SOCIAL SECURITY NO 17. INFORMANT BEN-J. G.	eyetko #2	
law requires that the death certificate be executed within 24 hours after death and physician. been signed by the ottending physician and completely fulled in by the funeral, is the burial-trons t permit. Then please remove corban appears Pages I gradition to burial, cremation, or removal, and in any event, within 72 hours after death	IB. CAUSE OF DEATH (Enter only one cause per pres for PART I. DEATH WAS CAUSED BY. 1	(0). (b). and (c)) eural Effrain au Otible + massire moto	d wearhe Dlewhopens 2 weaks	
4: The or offen or of	PART II. OTHER SIGNIFICANT COND TIONS CONTRIBUTING TO	T	PERFORMED? YES \(\text{NO} \) NO	
DING PHYSICIAN by the hospitol offer this certifica be detoched for Stote Dept. of He	20c. TIME OF INJURY Month, Doy, Year Hour a.m. p.m. 19 21. 1 certify that (1) (Nashaspital) attended	t of work		
AL OR ATTENDING by be retained by it controls. I DIRECTOR: After it controls a should be defiled with the Stote	saw the deceased alive an 11	2 2 19 6 7, and that death accurred of M.D. ATTENDING M.D. PHYS	7 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	
TO HOSPITAL OR ATTEND Page 4 moy be retained TO FUNERAL DIRECTOR: A director, page 3 should Should be filed with the	22c PHYSIC AN S NAME (Type) ROBERT RILLS 23a BURIAL, CREMATION, 23b. DATE THEREOF REMOVA, (Soprify) 1/-27-47	23c. NAME OF CEMETERY OR CREMATORY HILLCREST	PAPOLIS, MD. 23d LOCATION (City or Town) (County) (State) HNNAPOLIS A.A. MD.	
VR A15 (4)	24. JUNERAL DIRECTOR Low Com	1. md	CO BY REGISTRAR 1 256 REGISTRAR'S SIGNATURE NOV 2 8 1967 PERSONER, Processing Processin	



1 . 4	Items 18, 19, 21 MARYLAND STATE DEPARTMENT OF HEALTH film #395 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				
FOR STATE	12-6-67 mt 14824 MEDICAL EXAMINER'S CERTIFICATE OF DEATH	32			
HEALTH DEPT.	1 PLACE OF DEATH o. COUNTY Anne Arunde1 2 USUAL RESIDENCE (Where deceosed lived if institution Residence before or STATE MARYLAND MARYLAND Anne Arunde1	odmission)			
P p 33.	White RURAL and give negret town. Davidsonville	,			
te Ueg		S RESIDENCE ON A FARM? ES NO			
offer death 3 Give Page along with with the Stot	3 NAME OF First Middle Last 4 DATE Manth Doy OF (Type or print) EMMA HARRIS DEATH November 4,	Year 19 67			
within 24 hours offer death. In pencul in Item 18 Give Pages Exominer's Office along with for File pages 1 and 2 with the State? Hours offer death.	Female Negro W DOWED D VORCED 3-7-1927 40 vrs Months Doys	Hours Min			
e should be executed within 24 hours of the word "pendimg" in pencil in Item 18 to the Chief Medicol Exominer's Office a buriol-tronsit permit. File pages 1 and 2 win any event within 72 hours ofter death.	10o. US_AL OCC_PATION (Give kind of work done during grost of working life even if retired) 10b. KIND OF B_SINESS OR 11. BIRTHPLACE (State or foreign country) 12. CU ZEN_OF COLNTRY COLNTRY)	WHAT .			
I within 24 in pencil in Exominer's Exominer's File pages 12 hours offer	Garph Fohmen Emma Maynaul	1			
executed vinding in Medicol Experimit Filmwithin 72 l	15/ WAS DECEASED EVER IN L S ARMED FORCES? (Yes, m) or upknown) (If yes give wor or dotes of service) 16 SOCIAL SECURITY NO 17 INFORMANT Address Address Address Address	collde			
be execut l'pendimg' hief Medica consit permi	PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute Alcoholie Intoxication ONSE	RVAL BETWEEN ET AND DEATH			
should be e ne word 'per to the Chief I buriol-tronsit	Conditions, if ony, which gave (b) (b)				
frate ing th rded to os a b	stoting the underlying couse (c) ast C c				
IER: This certificate should be executed within certificate, writing the word "pending" in pencil ould be forworded to the Chief Medical Examines. ihould be used as a burial-transit permit. File paging or removal, and in any event within 72 hours of	PART II OTHER SIGNIFICANT COND TIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAL DISEASE COND TON CIVEN N PART I(o) Arteriosclerotic Cardiovascular Disease YES	WAS AUTOPSY PERFORMED?			
기 설립 그 다	Arteriosclerotic Cardiovascular Disease 200 EXTERNA. CAUSE WAS PRIMARY Or CONTR BUTING CAUSE OF DEATH. 200 EXTERNA. CAUSE WAS PRIMARY Or CONTR BUTING CAUSE OF DEATH.				
MIN the the Jur fill e 3 s	20c T ME OF NJURY Month, Day, Year 20d NJURY OCCURRED While Not While of work	(State)			
MEDICAL EXA please Execute director. Page retained for you DIRECTOR: Page in to buriol, creming to buriol, creming to buriol, creming the page of the	21 i certify that I took charge of the remains described above, held an Autopsy (XX). Inspection [], Inquiry [], and in modern resulted from: Natural causes [XX]. Accident [], Suicide [], Homicide [], Undetermined manner []				
pleose ple	SIGNATURE MD ASSISTANT MEDICAL EXAMINER (2)	Z. DATE SIGNED			
TO DEPUTY MEGTCAL In necessory, please meet the funeral director. Pa 5 may be retained for TO FUNERAL DIRECTOR: Health prior to buriol, or	EXAMINER'S Werner U. Spitz, M.D. DEPUTY MED CAL EXAM NER Address (Street, city, town, or county)	\			
To Figure 1	230 BURIAL CREMATION, 236 DATE THEREOF 230 NAME OF CEMFTERY OF CREMATORY 230 DOCATION (C by or Town) (County). SEMOVAL (Specify) 1-9-1967 Detailed (County).)/(Storo)			
VR A15ME (5)	24 FUNERAL DRECTOR ADDRESS DATE INUV 1 0 1901 ADDRESS DATE INUV 1 0 1901	Judy			

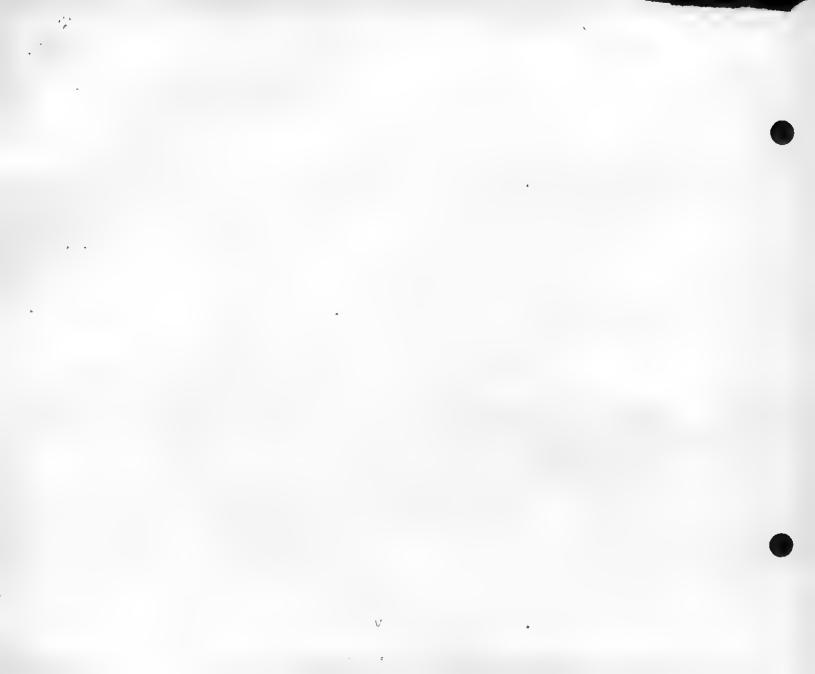


MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14833 14825 CERTIFICATE OF DEATH 24 haurs after death PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admiss on) o. COUNTY o STATE **b** COUNTY Anne Arundel Maryland Anne Arundel MARYLAND c CITY OR TOWN (It outside corporate limits, write RURAL and a ve nearest town) b CITY OR TOWN (If outside corporate imits. c LENGTH OF STAY IN 16 write RURAL and give nearest town) Annapolis Annapolis d, NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street oddress) d STREET ADDRESS e IS RESIDENCE ON A FARM? paper) Jack 38 Franklin Street NO IX Anne Arundel General Hospital requires that the death certificate be executed within NAME OF 4 DATE Last Month Dov Year DECEASED camplete ond in any event, Type or print) HEALY DEATH November Faunt leroy Roberta AGE (In years last birthdoy) IF UNDER 24 HR S SEX 6 COLOR OR RACE 8. DATE OF BIRTH IF UNDER 7 MARRIED NEVER MARRIED Months Dovs Hours November 29,1889 DIVORCED. Female White 100 USUA, OCCUPATION (Give kind of work done 12 CITIZEN OF WHAT KIND OF BUSINESS OR 11, BIRTHPLACE (County & Stote, or foreign country) physician a nen please ducing most of working life_eyen if retired) COUNTRY? Virginia U. S. 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME burial, cremation, or removal, WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unknown) (If yes give wor or dotes of service) 18 CAUSE OF DEATH (Enter only one couse per one for (o), (b), and (c).) INTERVAL BETWEEN ONSER AND DEATH signed by the burial-transit PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) 10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires the Page 4 may be retained by the haspital ar attending physician. DUE TO Conditions, if ony, which gove rise to immediate cause (a), DUE TO stoting the underlying couse director, page 3 shauld be detached far use as the should be filed with the State Dept. of Health priar to 19 WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 2 NO TO FUNERAL DIRECTOR: After this certificate 20g ACCIDENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port I of term 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form (City or town) (County) 20c TIME OF INJURY Month, Doy, Year factory, street, office bldg . etc) Not While of work 21. I certify that (1) (this hospital) attended the deseased from sow the deceased alive an and that death occurred at from causes and an the date stated obove 22o. SIGNATURE 22b DATE SIGNED MD DIRECTOR 22c PHYS.CIANT 22d. ADDRESS NAME (Type) 23b DATE THEREOF BURIAL, CREMATION. 23C-NAME OF CEMETERY OR CREMATORY LOCATION (City or Town) FUNERAL DIRECTOR REC D BY REG STRAR VR A15 (4) 25M 1/67 0001 : w. lan

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14825 14834 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) PLACE OF DEATH a. COUNTY a. STATE b. COUNTY Anne Arundel Anne Arundel MARYLAND Maryland b CITY OR TOWN (f autside carparote limits, write RURAL and give nearest town) c LENGTH OF STAY IN 15 c CITY OR TOWN (If gatside carporate limits, write RURAL and give nearest town) Pasadena Glen Burnie 4 vears e IS RESIDENCE ON A FARM? d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS pope 72 fillogi. NO J 7689 Briar Lane YES North Arundel Hospita NAME OF Middle 4 DATE Month Lost Doy the attending physicion and completely sit permit. Then please remove corbar DECEASED
(Type or print) Visa M. Hess DEATH November 26 please remove cor 9 AGE (In years IF UNDER 1 YEAR JE LIA DER 24 HRS S SEX 8 DATE OF BIRTH 7. MARRIED NEVER MARR ED Manths lost birthday) Doys Hours WIDOWED DIVORCED White Female 1-11-91 12 CIT ZEN OF WHAT 10a, USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or foreign country) COUNTRY? during most of warking life, even if retired) INDUSTRY Viroinia US.A Housework Own Home 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME (Haknown) Henry Miller 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17. INFORMANT (Yes, ng. grunknawn) (if yes give war ar dotes af service Silas Honaker (son) Baltimore, Md INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter on y one cause per line for (o), (b), and (c).) signed by the buriol-transit p ONSET AND DEATH PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) DUE TO burnal. Canditians, if ony, which gove rise to immediate cause (o), DUE TO stoting the underlying couse as the prior to l Page 4 may be retained by the hospital or attending O FUNERAL DIRECTOR: After this certificate has been lan WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) PERFORMED? USe ND for 200 ACCIDENT WAS UNDERLYING [20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20f. (City or tawn) (State) 20d INJURY OCCURRED 20e. PLACE OF INJURY (Hame, form, (County) 20c TIME OF INJURY Month, Day, Year foctary, street, affice bldg, etc.) Hour a.m. Nat While of work at work 1967, that (I) (we) last 21. I certify that (1) (this haspital) attended the deceased fram director, page 3 should should be filed with the 11/26 1967, and that death accurred at 33 PM, from causes and an the date stated above saw the deceased alive an. 22b DATE SIGNED 22o. SIGNATURE ATTENDING M.D. DIRECTOR PHYS 22d ADDRESS 22c PHYSICIAN S NAME (Type) 23b. DATE THEREOF NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) -/06 [Store 230 BURIAL, CREMATION REMOVAL (Specify) Glen Hawen Memorial Park Glen Burnie. Maryland Jov. Singleto HORF Uneral Home 250 RECO BY REGISTRAP 25b. REGISTRAR S SIGNATURE 24. FUNERAL-DIRECTOR VR A15 (4) DATE en Burnie. Marvland 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH 14827 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14835 CERTIFICATE OF DEATH 24 hours after death PLACE OF DEATH 2 USUAL RESIDENCE OWhere deceased fived, if institution. Residence before admiss an) a. COUNTA MARYLAND TOWN/(If autside carparate c LENGTH OF STAY IN 16 c CITY_OR-TOWN (if autside carparate timits, write RURAL and give negrest INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS ON A FARM? YES NO & The law requires that the death certificate be executed within 3. NAME OF Year DECEASED maine and in any event, (Type or pnnt) 7 MARRIED NEVER MARRIED last burthday) Manths Hatis WIDOWED K DIVORCED 10b. KIND OF BUSINESS OR 10a. US_ALOCCHPATION (Give kind of work done 12 CITIZEN OF WHAT 11. BIRTHPLACET during most alfwarking life even if retired 13. FATHER S. MANN crematian, or remayal, IS WAS DECEASED EVER IN U.S. ARMED FORCES? INFORMANT 36. SOCIAL SECURITY NO (Yes, no runknawn) (If yes give war or dates af service Grace lemeade 18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c),) INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) **IO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires the Page 4 may be retained by the haspital ar attending physician. DUE TO burial Canditions, if any, which gave rise ta immediate cause (a), DUE TO stating the underlying cause director, page 3 should be detached far use as the should be filed with the State Dept. af Health priar to 19 WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIB TING TO DEATH BUT NOT RELATED TO THE JERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, farm, (City or town) 20c TIME OF INJJRY Month, Day, Year (Caunty) (State) factory, street, affice bldg , etc.) Hauria.m. Nat While at wark TO FUNERAL DIRECTOR: After 21. I certify that (1) (this hospital) attended the deceased from 19___, that (I) (we) last 1962, and that death occurred av220 AM, from causes and on the date stated above saw the deceased alive on____ 22g. SIGNATURE 22b DATE SIGNED ATTENDING PHYS. DIRECTOR . M.D. 22c. PHYSICIAN'S 23a BUR AL, CREMATION, 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) REMOVAL (Specify) Colmar Planor Pro Geo Md. Burial Nov 15, 1967 Ft Lincoln Cemetery 24. FUNERAL DIRECTOR 2Sa. REC'D BY REGISTRAR 2Sb. REGISTRAR'S SIGNATURE VR A15 (4 F. Gasch's Sons

Hyattsville, Md.

DATE NOV

Wilianeas Judge



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14836 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR STATE HEALTH DEPT. PLACE OF DEATH USUAL RESIDENCE (Where deceased lived of institution Residence before admission) o. COUNTY p. STATE b COUNTY MARY, AND ô b CITY OR TOWN (If outside corporate limits. C JENGTH OF STAY IN B c CTY OR TOWN (if outside corporate imiti write RURA, and give nearest town) write RURAL and give nearest town) d NAME OF HOSP TAL OR INSTITUT ON (If not in hospital, give street address) IS RES DENCE ON A FARM? d STREET ADDRESS 40 NOK Give_Pages Stot 3. NAME OF DATE Lost Dov Year KONDO DECEASED OF HOLZ (Type or print) DEATH S. SEX F UNDER 1 YEAR 6 COLOR OR RACE 7 MARRIED NEVER MARRIED DATE OF BIRTH 9 AGE (In years IF UNDER 24 HRS olo Days ost birthdoy) Hours within 72 hours ofter death WIDOWED DIVORCED 6-12-67 and 2 1Do JSUAL OCCUPAT ON (Give kind of work done 10b K ND OF BUSINESS OR 11 BIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT COUNTRY 2 during most of working life, even if retired) INDUSTRY 13 FATHER'S NAME 14 MOTHER SMAIDEN NAME DiGNUE HENDER SON WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANT 16 SOCIAL SECUR TY NO Address (Yes, no, or unknown) If If yes give war or dates of service) 1B CAUSE OF DEATH (Enter only one couse per line for (o), (b)
PART I DEATH WAS CAUSED BY NTERVAL BETWEEN ONSET AND DEATH evillin IMMEDIATE CAUSE (o) This certificate should DUE TO QUÀ Conditions, if any, which gave 3 rise to immediate cause (a). 9 DUE TO stating the underlying cause farwarded PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN N PART (6) 19 WAS AUTOPSY removal, PERFORMED? certificate, NO X 200 EXTERNAL CAUSE WAS 20b DESCRIBE HOW NICRY OCCURRED (Enter nature of injury in Port I or Port II of item 18.) 3 should PRIMARY CONTRIBUTING 0 EXAMINER: CAUSE OF DEATH cremation, 2Dc I.ME OF INJURY Month, Day, Year 20d (NJURY OCCURRED 20e, PLACE OF .NJURY (Home, form (City or town) (County) (Stote) Not While factory, street, office bldg., etc.). DIRECTOR: Page please execute of work at work 21. I certify that I taok charge of the remains described above, held an Autopsy Inspection 4. Inquiry 19 and in my apinion Natural causes deoth resulted from Suicide _______, Accident Hamicide Undetermined manner be retained CHIEF MEDICAL EXAMINER ACTUAL 22 DATE SIGNED prior 1 ASS STANT MEDICAL EXAMINER SIGNATURE funeral FUNERAL DEPUTY MEDICAL EXAMINER **EXAMINER'S** Mag 1th NAME (Type) Address (Street, city, town or county) 23c NAME OF CEMETERY OR CREMATORY 230 BUR AL CREMATION. 23b DATE THEREO 23d LOCATION Inity or Tawn) (Stote) (County) Bernal (Specify) 9 Hillerest Cometenu RECD BY REGISTRAR 25b REGISTRAR S SIGNATURE 24. FUNERAL DIRECTOR VR A15ME (5) DATE NOV

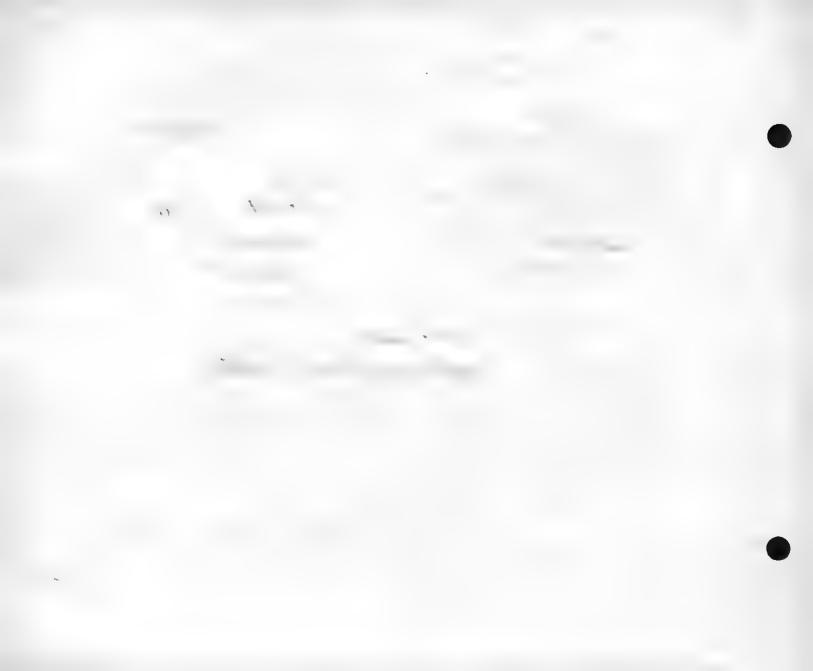




MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14828 CERTIFICATE OF DEATH 24 hours after death 2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) and PLACE OF DEATH o. COUNTY o. STATE Anne Arundel MARYLAND Anne Arundel Marvland b CITY OR TOWN (if outside carporate limits. c CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town) c LENGTH OF STAY IN 15 write RURAL and give nearest town) Glen Burnie d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS e IS RESIDENCE ON A FARM? Blvd. iled YES NO T Balto. & Annapolis Arundel The law requires that the death certificate be executed within 3 NAME OF Last Year DECEASED DEATH (Type or print) COL Houck event, 9 AGE (In years IF UNDER I YEAR FUNDER 24 HRS S. SEX 8 DATE OF BIRTH 7 MARRIED NEVER MARRIED last birthday) Months Days White or removal, and in any Male WIDOWED DIVORCED 10a, USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR Sounds & State, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? INDUSTRY physician Bartender Night Club MXXXXXXX. Marvland 11.5 A 13. FATHER S NAME 14. MOTHER'S MA DEN NAME ottending phys Flla Rohrbauch Claude Houck 17. INFORMANT 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO Address (Yes, no, or unknown) (If yes give war ar dates af service) 216 07 4691 Mrs. Theresa M. Houck (wife) Same As unknown burial, cremation, CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c)) INTERVAL BETWEEN ONSET AND DEATH burnal-transit PART I DEATH WAS CAUSED BY My oca IMMEDIATE CAUSE (a) signed by Poge 4 may be retained by the haspital or attending physician. DUE TO Canditions, if any, which gave rise to immediate couse (a), DUE TO stating the underlying couse this certificate has been os the WAS AUTOPS' PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) USe Stote Dept. of Heolth YES 🗍 NO 0 20g ACCIDENT WAS UNDERLYING [7] 205 DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) OR CONTRIBUTING CAUSE OF DEATH detoched (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (State) 20c TIME OF INJURY Month, Day, Year Not While factory, street, office bldg., etc.) at wark FUNERAL DIRECTOR: After I fram 10 20/66 19 to 11/27/6/19, that (I) (we) last and that death accurred at 12 2 M, fram causes and an the date stated above 2). I certify that (I) (this haspital) attended the deceased fram. 25/67 saw the deceased alive an... 22a SIGNATURE 225. DATE SIGNED STAFF M.D PHYS DIRECTOR 22d. ADDRESS PHYSICIAN'S NAME (Type) director, p 235 DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stote) 230. BURIAL, CREMATION REMOVAL (Specify) Nov. 30/67 Glen Haven Memorial Park Glen Burnie. Maryland 0 DATE NOV 29 FUNERAL DIRECTOR Singleton Funeral Home 2Sb REGISTRAR'S SIGNATUR Charles Rlen Burnie, Maryland



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14339 14830 CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 haurs after death 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) ANNE ARE H completely-filled in by the funera o. COUNTY a. STATE b COUNTY MARYLAND CLENGTH OF STAY IN 16 h City OR TOWN (If outside corporate imits, c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) e IS RES DENC d STREET ADDRESS SNSTITUTION (If not in Jagspital Javive street address) ON A FARM MO [YES Month NAME OF Middle DATE Year Lpau First . Dov DECEASED 19 61 DEATH (Type or print) 6 F UNDER 24 HRS SE LINDER I YEAR AGE (In years S SEX 6. COLOR OR RACE DATE 7 MARRIED NEVER MARRIED last hirthday) Months Hours Doys WIDOWED DIVORCED and in any 10c USUAL OCCUPATION (Give kind of work done 10h KIND OF BUSINESS OR TI BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT physician a during most of workut te, even if retired) INDUSTRY COUNTRY? U.S.A. Washinglaw un Ruann Actor 13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME ar removal. JOHN 17 INFORMANT 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO Address permit. (Yes, no, or unknown) If If yes give war or dates of service) crematian, INTERVAL BETWEEN 1B CAUSE OF DEATH (Enter only one couse per line for (o), (b), signed by the burial-transit p ONSET AND DEATH PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (0) by the hospital or attending physician. DUE TO paget's decin+ HCVD + dialetes Canditions, if any, which gove rise to immediate couse (a). DUE TO stating the underlying cause as the of Health prior to has been last WAS AUTOPSY PERFORMED? PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) USE NO PC certificate PHYSICIAN: ĕ 20h DESCRIBE HOW INJURY OCCURRED (Enter nature of unjury in Port I or Port II of item 18) 200 ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH detached (IF E THER, NOTIFY MEDICAL EXAMINER) State Dept. MEDICAL (City or town) (Stote) 20d INBIRY OCCURRED 20e PLACE OF INJURY (Home, form, (County) TIME OF INJURY Month, Doy, Year Hour o.m. factory, street, office bldg., etc.) Not While at work **DIRECTOR:** After 67, 19___, that (t) (we) last 21 I certify that (V) (this hospital) attended the deceased fram Page 4 may be retained and that death accurred at M, fram causes and an the date stated above. saw the deceased alive an 22b. DATE SIGNED 22n SIGNATURE MD DIRECTOR PHYS ADDRESS 22d. 22c. PHYSICIAN'S TO HOSPITAL FUNERAL RENEDILI NAME (Type) director, should be 23b DATE THEREOF NAME OF CEMETERY OR CREMATORY (City or Town) (County) (Stote) 23c BURIAL CREMATION 230 REMOVAL (Specify) RUELA 9 250 REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR



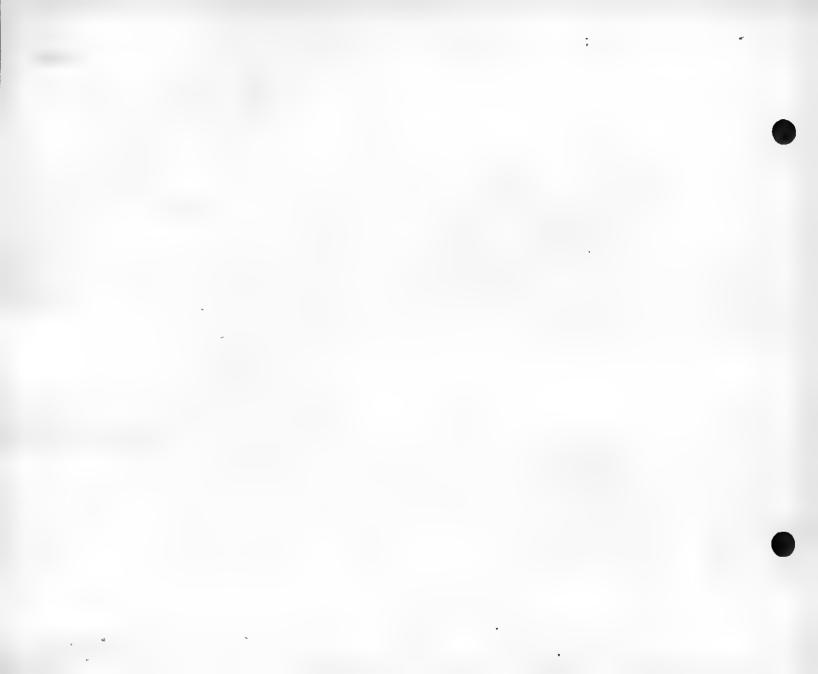
MARYLAND STATE DEPARTMENT OF HEALTH



	DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1		
	14932 CERTIFICATE OF DEATH		
1.	b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) d. NAME OF HOSPITAL OR INSTITUTION (if pot up hospital give street eddees) d. NAME OF HOSPITAL OR INSTITUTION (if pot up hospital give street eddees) d. STREET ADDRESS.	b, COUNTY	
3.	d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street eddress) OPER CONU, Heme, Merris Hill 4001 Woodridge NAME OF DECEASED (Type or print) NAME OF DECEASED (Type or print)	Month Dey Y	
10	6. COLOR OR RACE 7 MARRIED NEVER MARRIED 8. DATE OF BIRTH 9 AGE MDLE NEGRO WIDOWED DIVORCED 5/13/879 100. USUAL OCCUPATION (Give kind of work done during most, of working life, even if retired) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foleign most, of working life, even if retired)	(in yeers IF UNDER 1 YEAR IF UND birthdey) Months Deys Hours	
	UNKNOWN 3. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT 16. To or unknown (Ifyasgivewarordetesofservice)	L.S.A.	
ATION	geva rise to immediate cause (a), stating the underlying out to difference are the Manifer to	INTERVALIANSET AN SELLELAN SEL	
MEDICAL CERTIFICATION	20c. TIME OF INJURY Month, Dey, Year 20d. INJURY OCCURRED 20s. PLACE OF INJURY (Home, farm, forth, p.m. 19 20f. (City or low fectory, street, office bldg., etc.)	em 18) wn) (County)	
	saw the deceased alive on	causes and on the date state AFF YS. AFF Cu Burnu, Md 2	
23	3a. BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION Burial 11/4/67 Hopkins Chapel Clarksvi		



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14833 MEDICAL EXAMINER'S CERTIFICATE OF DEATH FOR (S 2 USUAL RESIDENCE (Where deceased lived, finst tution Residence by PLACE OF DEATH o STATE **b** COUNTY o. COUNTY MHCO MARYLAND CTY DR IDWN (If outside corporate ..m.ts, write RURAL and give nearest town) c CITY DR IOWN (If outside corporate limits, write RURAL and give nearest town) C. LENGTH DE STAY IN 16 HUNGBO /IS d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS S RESIDENC ON A FARM? PL 1- But 301 YES 🗍 ND 🔀 in pencif in Item 18. Give Pages This certificate should be executed within 24 haurs after death. 3 NAME OF 4 DATE Doy Year Midd e DECEASED 用eschKC、気動 19 (Type or print) DEATH 9 AGE (In years 5 SEX 6 CDLOR DR RACE 7 MARRIED NEVER MARRIED DATE OF BIRTH birthday) Months Doys Hours poges land 2 w ADRIL 23-1886 in any event within 72 haurs after death. WIDDWED K DIVDRCED 11 BIRTHPLACE (State or foreign country) 12 CITIZEN OF WHAT 100 USUAL DCCUPATION (Give kind of work done TOB KIND OF BUSINESS OF during most of working life, even if retiged) Washing on, Se hony yare pending" in penci in ef Medical Examiner's 13. FATHER 0) (Yes, no, or unknown) (If yes give wor or dotes of service 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I DEATH WAS CAUSED BY Onlineas levers please execute the certificate, writing the word DUE TO Conditions, if any, which gave (b) rise to immediate couse (a), DUE TD stoting the underlying couse 19 WAS AUTOPS'
PERFORMED? PART II, DTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) crematian, ar remayal. CERTIFICATION ND X 200 EXTERNAL CAUSE WAS 20b DESCRIBE HDW INJURY OCCURRED (Enter noture of injury in Port L or Port L of Item 18) 3 shauld PRIMARY | or CONTRIBUTING | CAUSE OF DEATH 20e PLACE DE INJURY (Home, form, (City or fown) 20c TiME DF NouRY Month, Day Year Hour o.m. foctory, street, office bldg, etc.) Not While may be retained far yaur FUNERAL DIRECTOR: Page ot work of work 21. I certify that I taak charge of the remains described above held an Autapsy Inspect on 🖊 and in my opinian Undetermined manner Natural causes Accident Suicide , hamicide death resulted from: CHIEF MEDICAL EXAMINER ACTUAL 22 DATE SIGNED ASS STANT MED CAL EXAM NER SIGNATURE the funeral DEPUTY MEDICAL EXAMINER **EXAMINER'S** Address (Street city town or county) NAME Type 23c NAME OF CEMETERY DR CREMATORY 23d LDCATION (City or Town) 230 BURIAL CREMATION 23b DATE THEREOF (County) (Stote) 50 REMDYAL (Specify) Suitland, Maryland Cedar Hill Cemetery 250 REC D BY REGISTRAR 25b REGISTRAR S SICNALIJRE 24 FUNDRAL D RECTOR VR A15ME (5) Bros. 1661-Gd. Hope Rd. SE. Wash. DC



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 11,024 death. yours after death the funeral 2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) . PLACE OF DEATH a. COUNTY g. STATE b. COUNTY Prince Georges hours after MARYLAND b CTY OR TOWN (If autside carparate limits, c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c LENGTH OF STAY IN 15 write RuRAL and give nearest tawn) Glen Burnie 24 Hrs. Md. Bowie e IS RES DENCE ON A FARM? d NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d STREET ADDRESS event, within 72 h within 24 filled YES NO IX 2802 Stindle Lane Manth Amanda] 3 NAME OF Middle 4 DATE Marth Day Year completely. DECEASED OF Jahn , Sr. William H. Nov. 26 1967 (Type or print) DEATH requires that the death certificate be executed AGE (In years S SEX IF UNDER 1 YEAR IF UNDER 24 HRS 6 COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH remave last birthdoy) Manths Days Hours and in any WIDOWED DIVORCED puo 100 USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 12 CIT ZEN OF WHAT 11 BIRTHPLACE (County & State, or foreign country) COUNTRY? U.S.A. during most of working life, even if retired)
Retired Watch Maker INDUSTRY signed by the attending physician burial-transit permit. Then please Missouri 14. MOTHER'S MAIDEN NAME 13 FATHER'S NAME burial, cremation, ar remaval, Isahelle Omar Brazealle WAS DECEASED EVER IN U.S. ARMED FORCES? INFORMANT 16 SOCIAL SECURITY NO. (Yes, na, ar unknown) (If yes give wor or dotes of service samp as 2 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c), PART I DEATH WAS CAUSED BY INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE CAUSE (o) 220 Page 4 may be retained by the haspital ar attending physician. DUE TO Cardio Vorced Di Conditions, if any, which gave rise to immediate cause (a), DUE TO stating the underlying couse detached far use as the e Dept. af Health prior to has been 19. WAS AUTOPSY PART II, OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) HEDICAL CERTIFICATION PERFORMED? YES No O FUNERAL DIRECTOR: After this certificate 20a ACCIDENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER director, page 3 should be detache shauld be filed with the State Dept. (City or town) TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (County) (Stote) Nat While factory, street, affice bldg., etc.) OR ATTENDING at wark of work 21. I certify that (I) (this hospital) attended the deceased from and that death accurred at 10550 M, fram causes and on the date stated above saw the deceased alive on 22g SIGNATURE 22b. DATE-SIGNED ATTENDING M.D. PHYS. 22d ADDRESS PRYSICIAN'S NAME (Type) 23b DATE THEREOF 23c. NAME OF CEMBIERY OR CREMATORY 23d LOCATION (City or Town) (County) 23g BURIAL CREMATION. (Stote) REMOVAL (Specify) Pacific, Missouri Pacific Cemetery 25o. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR **VR A15 (4)** 1967 Kirkley Funeral Home, Glen Burnie, Md. 20 M 1/66



1 1		IND STATE DEPARTMENT OF HEALTH S, 301 W. PRESTON STREET, BALTIMORE, MARYI	AND 21201
	<u>14935</u>	CERTIFICATE OF DEATH	14844
unefol 1 and 2 2r death	O. COUNTY Crammel Stet Respon	2 USUAL RESIDENCE (Where deceosed o. STATE M.	b COUNTY Aug.
tours affected by the funefol s. Pages I and hours after death	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		limits, write RURAL and give nearest tawn)
nin 24-hou	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, g ve stree Craumsnik State Respital	d. STREET ADDRESS 76 Success feld	be Drave e is residence on a FARM? YES NO P
letely fi corbon int, with	3 NAME OF First Haward (Type or print) Haward	Middle Lost 4 DATE OF DEATH	Month Doy Year 1 19 67 AGE (in years I FUNDER YEAR F JNDER 24 HRS
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ate be ician or leose re and in	100. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Were dance from the control of BU INDUSTRY	USINESS OR 11 BIRTHPLACE (County & Stote, or forei PAY 14, MOTHER'S MAIDEN NAME	COUNTRY?
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that the in. by the ronsit p	18 CAUSE OF DEATH (Enter only one couse per line for (o), (b), PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (o)	uaua.	ONSET AND DEATH
4 may be retained by the hospital or attending physician. 4 may be retained by the hospital or attending physician. 4 may be retained by the hospital or attending physician. 4 may be retained by the hospital or attending physician. 5 were DIRECTOR: After this certificate has been signed by the ottending physician and completely filled in by tor, page 3 should be detached for use as the burial-transit permit. Then please remove corban pagets. Plabe filed with the State Dept. of Health pract to burial, cremation, or removal, and in any event, within 72 hours.	Conditions, if any, which gave (b) USE 10 isse to immediate cause (a), (b)	all	
ICIAN: The faw repital or attending rificate has been of for use as the of Health prior to	stoting the underlying couse (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH	4 BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN	IN PART I(c) 19 WAS AUTOPSY
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OR ATTENDING PHYSICIAN De retained by the hospital of IRECTOR: After this certificat e 3 should be defoched for ed with the State Dept. of Hee	saw the acceased aliye an 11/4/67 220. SIGNATURE	_19, and that death accurred at 6.24 M,	
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TO HOSPITAL OR ATTENDING PHYSICI Page 4 may be retained by the hospit TO FUNERAL DIRECTOR: After this certification, page 3 should be defoched should be filed with the State Dept. of		NAME, OF CEMETERY OR CREMATORY 23d 10C	ATION (City or Town) (County) (State)
E-E X	REMOVAL (Specify) 24 PUNERAL DIRECTOR	ADDRESS 250 RECD BY REGISTRA	
VR A15 (4) 25M 1/67	phy 14 Jay To Saw (lun	crows views 104NOV 15 1	967 Charles gray



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14836 CERTIFICATE OF DEATH 14845 funeral 1 and 2 er death. 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) PLACE OF DEATH b COUNTY o. COUNTY o. STATE MARYLAND ANNE ARUNDEL ANNE ARUNDEL MARYLAND c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

ANNAPOLIS, MD. b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 24, hours ANNAPOLIS d STREET ADDRESS e IS RES DENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) 2B Eucalyptus Rd. NAVAL HOSPITAL, ANNAPOLIS YES NO X The law requires that the death certificate be executed within 3. NAME OF Middle 4. DATE Month Year JOSE GIRL NOV DECEASED BABY 1967 (Type or print) DEATH IF JNDER 24 HRS 6 COLOR OR RACE 8 DATE OF BIRTH AGE (In years IE LINDER I YEAR 7 MARRIED NEVER MARRIED lost birthday) Hours Nov. 1967 Fema le Cauc. WIDOWED DIVORCED 12. CITIZEN OF WHAT 1Do. USLAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & State, or foreign country) during plosy of working life, even if retired) PHTRY? LIPINES INDUSTRY PHILLIPINES 14. MOTHER'S MAIDEN NAME 13. FATHER S NAME cremation, ar remayal, JESUS BELBIS JOSE LINDA NONE BAOL Address 16 SOCIAL SECURITY NO 17. INFORMANT 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, go, of unknown) (If yes give war or dotes of service) MOTHER 18 CAUSE OF DEATH (Enter only one couse per line for (a) (b) and (c) INTERVAL BETWEEN ONSEL AND DEATH signed by the burral-transit PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate couse (a), DUE TO stoting the underlying couse this certificate has been PART 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPS 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I of Item 18) 20o. ACC DENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) (City or town) 2Dd INHURY OCCURRED 2De PLACE OF INJURY (Home, form, (County) (Stote) 2Dc TIME OF INJURY Month, Day, Year foctory, street, office bldg., etc) Hour o.m. Not While ot work 21 I certify that (I) (this haspital) attended the accessed fram 1 November, 19.67, pto 2 November, 19.67, that (I) (we) last saw the deceased alive an 2 November 19.67, and that death accurred at 1255 M, fram causes and an the date stated above. 22b. DATE SIGNED 220 SIGNATURE 2 Nov. 1967 ATTENDING MED DIRECTOR X PHYS 22c. PHYSICIAN S HOSPITAL, ANNAPOLIS, MD. TO FUNERAL KILLINGER, LCDR MQ NAME (Type) 230. BURIA., CREMATION? 23c NAME OF CEMETERY OR CREMATORY 23d JOCATION (City or Town) (County) (Stote) REGISTRAR S SIGNATUR VR A15 (4) Gloucester Minutes Judge 1967 DATENDV nnapolis. Md

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1	Item 21 Film 396 12-21-67MARYLAND STATE DEPARTMENT OF HEALTH ams Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
FOR STATE	14837 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 16352
HEALTH DEPT.	PLACE OF DEATH O COUNTY 2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) O STATE D. COUNTY
delay is and 3 to M3. Page	Anne Arundel MARYLAND Maryland b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest fown) write RURAL and cive nearest fown) Crownsville 2 years Baltimore
Property of the Park	Crownsville 2 years Baltimore d NAME OF HOSP TAL OR INSTITUT ON (If not in hospitol, give street oddress) d STREET ADDRESS e IS RESIDENCE ON A FARM
Pages 1, rith farm	Crownsville State Hospital 708 South Broadway YES NO
after death 8. Give Page along with with the year	3. NAME OF First Middle Lost 4 DATE Month Doy Year DECEASED (Type or print) John Karsten DEATH 11 13 19 67
	S. SEX 6 COLOR OR RACE 7 MARRIED NEVER MARRIED B DATE OF BIRTH 9 AGE (In years IF UNDER 1 YEAR IF UNDER 24 F
hin 24 haurs ned in Item 18 niner's Office o pages land 2 v n any event	100 USUAL OCCUPATION (Give kind of work dane during most of working life, even if retired) 10b KIND OF BUSINESS OR 11 BIRTHPLACE (State or foreign country) 11 COUNTRY?
ed within 24 in pencil in 1 Examiner's (Examiner's Control of the pages 1 and a any control of the any control of the pages 1 and a any control of the any control of	13 FATHER'S NAME 14 MOTHER'S MA DEN NAME
ed wit In pe Il Exar I. Fle I. and	Max Karsten IS WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service) 16. SOCIAL SECURITY NO 17 INFORMANT Address
This certificate shauld be executed within 24 haurs cate, writing the ward "pending" in pencil in Item 1 be farwarded to the Chief Medical Examiner's Office be used as a bural transit permit. Fle pages 1 and 2 r to burial, cremation, ar remaval, and n any event	no unknown Hospital Records, Crownsville, Maryland 18. CAUSE OF DEATH (Enter only one cause per line for (o), (b), and (c)) PART I. DEATH WAS CAUSED 8Y ONSET AND DEATH ONSET AND DEATH
s certificate shauld be, writing the ward farwarded to the Chieves a burial trains a burial trains.	Conditions, if ony, which gove) (b) Fat embolism (rise to Immediate couse (g),
ficate ing th ded to des a b as a b If, cren	storing the underlying couse lost (c) Fracture of neck of left femur
s certifica e, writing farwarde g used as a burial,	PART II OTHER'S GNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(0) 19 WAS AUTOPSY PERFORMED? PSychoneurotic Depressive Reactions; marked YES NO
# <u> </u>	Psychoneurotic Depressive Reactions; marked 200 EXTERNAL CAUSE WAS PRIMARY Or CONTRIBUTING A 20th DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port or Port of tem 18) Patient fell down in the bathroom 20th INJURY Month, Doy, Yeor Hour om While Not While County) (County) (Stote foctory, street, office bldg, etc.)
3 9 4 年 5 年	20c. Time Of INJURY Month, Doy, Yeor 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, Hour om Hour om While of work Occurrent) Crown ville St. Hos. Crownsville A.A. MD.
Cecute Rege far ya OR: Pag	21 certify that I toak charge of the remains described abave, held an Autopsy [], Inspection [], Inquiry [], and in my opin
DEPUTY MEDICAL EXAM ressary, please execute the funeral director. Page 4 may be retained for your FUNERAL DIRECTOR: Page eaith or its designated age	death resulted from Natural causes X, Accident , Suicide , Homicide , Undetermined monner . CHIEF MEDICAL EXAMINER
O DEPUTY I	SIGNATURE M. D ASSISTANT MEDICAL EXAMINER DEPUTY MED CAL EXAMINER M. D ASSISTANT MEDICAL EXAMINER DEPUTY MED CAL EXAMINER Address (Street, city, town, or county) 11-13-67
TO DEP necessor the fur 5 may TO FUNE	230 BURIAL CREMATION, REMOVAL (Specify)
VR A15ME (5)	24 FUNERAL DIRECTOR ADDRESS 250 REC'D BY REGISTRAR 25D REGISTRAR'S SIGNATURE DATE DEC 7 1967 Yelloweley Ymoge



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14838 MEDICAL EXAMINER'S CERTIFICATE OF DEATH PLACE OF DEATH USUAL RESIDENCE (Where deceased lived if institution Residence before admission o COUNTY b. COUNTY 10 and 3 Pa b. CITX OR TOWN outside corporate r JENGTH OF STAY IN In (If outs de corporate limits, write RURAL and give nearest town) CITY AR TOWN and give negrest/fowe) NAME OF HOSPITALIOR INSTITUTION (If not in hosp to give street oddress) d STREET ADDRESS e IS RES DENCE ON A FARM? YES NO S in Item 18. Give Pages 24 haurs after death NAME OF Middle Doy Year Office alang with DECEASED OF DEATH within 196 Type or print' S SEX AGE (In years MARRIED NEVER MARR ED Months Doys Hours WIDOWED D VORCED event 10o USUAL OCCUPATION (Give kind of work done 12 CIT ZEN OF WHAT ÛЪ during most at working life, even if retired) COUNTRY ? pages 1 in any (d "pending" in penal in Chief Medical Examiner's 13 FATHERS NAME 14, MOTHER'S MAIDEN, NAME be executed within and 15 WAS DECEASED EVER IN U.S. ARMED FORCES 16 SOCIAL SECUR TY NO 17 ANFORMAN (Yes, no or naknown) (If yes give wor or dates of service remayal. INTERVAL BETWEEN IB. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c),) PART I DEATH WAS CAUSED BY **OASET AND DEATH** crematian, ar IMMEDIATE CAUSE (o) writing the ward This certificate should DUE TO farwarded ta the Conditions, if any, which gave rise to immediate couse (a), DUE TO stoting the underlying couse lost. burial, (19 WAS AUTOPS Y PERFORMED? PART I OTHER'S GNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) NO X please execute the certificate. designated agent, priar ta þe 20o EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of tem 1B.) PRIMARY Or CONTRIBUTING 4 shavid CAUSE OF DEATH. MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF NJURY (Home, form 20f (City or fown) (County) (State) Hour om While Not While factory, street, office bldg., etc.) FUNERAL DIRECTOR: Page of work of work described abave, held an Autapsy 21 I certify that I taak charge of the remains Inspection 7 and in my apinian the funeral directar. death resulted framu Natural causes Accident Suicide [Hamicide Undetermined manner be retained CHIEF MEDICAL EXAMINER ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIGNATURE TO DEPUTY DEPUTY MEDICAL EXAMINER Health or Address (Street city, fown, or county) NAME (Type 23b. DATE THEREOF BURIAL CREMATION-NAME OF CEMBTERY OR CREMATORY 23# LOCAT ON (City or Town) (County) (State) 0 2So. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE FUNERAL DIRECTOR ADDRESS VR A15ME (5) DATEDEC

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14847 CERTIFICATE OF DEATH 24 hoters ofter death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) COUNTY b county MARYLAND TARYLAND b CITY OR TOWN (If outside corporate limits, c LENGTH OF STAY IN 1h c C TY OR TOWN (If autside corporate limits, write RURA) and give nearest town write RURAL and give nearest town) ALTIMORE d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) patient d STREET ADDRESS IS RES DENCE YES NO Z requires that the death certificate be executed within NAME OF remove carban DATE Month Year **DECFASED** OF **LLORENCE** Type or pont DEATH SEX 6 COLOR OR RACE 8 DATE OF BIRTH AGE (In years IF UNDER 1 YEAR 7. MARRIED NEVER MARRIED IF UNDER 24 FIRS lost birthdoy) Months Doys Hours 4-26-WIDOWED DIVORCED 10o. US JAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR 11 BIRTHPLACE (County & Stote, or foreign country) 12 CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? INDUSTRY attending physician sermit. Then please SCHOOL BALTO CC 13 FATHER'S NAME 14. MOTHER'S MAIDEN NAME ar removal, TOHNSON WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT (Yes, no, or unknown) (If yes give wor or dates of service 9 EENTIE AUE JANET W.000 signed by the attent burial-transit permit burial, cremation, a 18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (INTERVAL BETWEEN PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) DUE TO Conditions, if ony, which gove rise to immediate couse (a) DUE TO as the priar to b stoting the underlying couse PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) WAS AUTOPS PERFORMED? of Health YES . NO 20o ACC DENT WAS UNDERLYING [20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF NJURY (Home, form, Page 4 may be retained by the h o FUNERAL DIRECTOR: After this (City or town) (Stote) foctory, street, office bldg , etc.) Not While of work 21. I certify that (1) (this haspital) attended the deceased fram. , and that death occurred at saw the deceased alive an 10 M, fram causes and an the date stated above 220 SIGNATURE DATE SIGNED D RECTOR director, page --22c PHYSICIAN S 22d. **ADDRESS** NAME (Type) 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 230 BURIAL CREMATION. 23d LOCATION (City or Town) (County) REMOVAL (Specify) 0 24 FUNERAL DIRECTOR VR A15 (4) 25M 1/67 SONS 300 MACE



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before edmission) a. COUNTY b. COUNTY anne arundel Co. Maryland MARYLAND inne arundel b. CITY OR TOWN (if outside corporate limits, C LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town, write RURAL and give nearest town) Hillsmere Shores Hillsmere Shores, Annapolis d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS . IS RESIDENCE ON A FARM? lete[] 506 Birch Drive 506 Birch Prive YES NOT 3. NAME OF Middle 4. DATE pap DECEASED OF [Type or print] DEATH Loraine withi carbon Klever pue (6. COLOR OR RACE B. DATE OF BIRTH 9. AGE (In yours | IF UNDER 1 YEAR Z. MARRIED | NEVER MARRIED | last birthday) event, Months Days WIDOWED DIVORCED [female remove 10a. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTRY [11. BIRTHPLACE (County & State, or foreign country) I 12. CITIZEN OF WHAT COUNTRY done during most of working life, evan if retired) public school retired teacher Maissouri please 2 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Norval L. Brady Mary Evans Then 15. WAS DECEASED EVER IN U.S. ARMED FORCES? removal, 16. SOCIAL SECURITY NO. | 17. INFORMANT Address (Yes, no, or unkown) | [If yes give war or dates of service] .irs ... Jone - sale as #2 above 18. CAUSE OF DEATH |Enter only one cause per line for (a), (b), and (c). 仑 ò ONSET AND DEATH PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause DUE TO (a), staling the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19 WAS AUTOPSY CERTIFICATION PERFORMED? но Г 20a ACCIDENT WAS UNDERLYING [206. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) After this OR CONTRIBUTING [CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) ATTENDING WEDICAL 20e. PLACE OF INJURY (Home, farm, | 20f. (City or town) 20c. TIME OF INJURY Month, Day, Yaar 204 INJURY OCCURRED I (County) (State) factory, street, office bldg., etc.) Not While Hour a.m. DIRECTOR: at work at work 21. | certify that (!) (this hospital) attended the deceased from, 19 ... /, that (I) (we) last saw the deceased alive on.... 22a SIGNATURE 22b. DATE HOSPITAL FUNERAL DIRECTOR PHYS. 22d, ADDRESS 22c. PHYSICIAN'S NAME (Type) director, be filled Richard Reeler vathedral St. Annapolis, 23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, lown or county) 10 REMOVAL (Specify) Hannibal, Marion Co. Grandview Cemeterv 24 FUNERAL DIRECTOR'S SIGNATURE 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE VR A15 (4) HOPPING FUNDA L LONG -20M S-63



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14843 CERTIFICATE OF DEATH 14149 **OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) PLACE OF DEATH " Anne Arundel **b** COUNTY Maryland MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
GLEN BURNIE CLENGTH OF STAY IN 15 c CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 3hrs. Baltimore d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e IS RES DENCI ON A FARM? North Arundel Hospital 4132 Annapolis Rd., Apt. 2A 3 NAME OF Middle First Lost 4 DATE Year DECEASED Knickman Charles H. DEATH November event, (Type ar print) IF JNDER 1 YEAR S SEX 6 COLOR OR RACE 7 MARRIED 8. DATE OF BIRTH 9 AGE (n years IF UNDER 24 HRS NEVER MARRIED Jost birthday) 7-9-98 and in any WIDOWED DIVORCED 10g ... SUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 1). BIRTHPLACE (County & State or foreign country) 12 CITIZEN OF WHAT during most of working life, even fret red) Glass Blower (bot physician (INDUSTRY **COUNTRY?** Baltimore, Md. U.S. (bottles) Md. Glass Corp 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME or remaya William Knickman Anna Stonesifer IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT Baltimore Address Md. 21227 (Yes, no, or unknown) (If yes give wor or dotes of service) 213-01-0492-A Mr. Daniel E. Knickman 2821 Michigan Ave. cremation. 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) INTERVAL BETWEEN PART I DEATH WAS CAUSED BY: ONSET AND DEATH IMMEDIATE CAUSE (o) DUE TO Conditions, if any, which gave rise to immediate couse (o), DUE TO stating the underlying couse this certificate has been of Health priar to WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NO [ò 20o. ACCIDENT WAS UNDERLYING [20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e. PLACE OF INJURY (Hame, farm, (City or town) (County) (State) factory, street, office blda., etc.) Not While of work Page 4 may be retained by 2). I certify that (I) (this haspital) attended the deceased from two-/, 19___, that (I) (we) las and that death accurred at M, from causes and an the date stated above saw the deceased alive an_ 22o. SIGNATURE 22b. DATE SIGNED **ATTENDING** MED. DIRECTOR PHYS 22c. PHYSICIAN'S 22d. ADDRESS NAME (Type) 23d LOCATION (City or Town) Houseprey) Co (Stote) 230. BURIAL CREMATION 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY Burial (Specify) Good Shepherd Cemeterv Ellicott City, Maryland 9 2Sa. REC'D BY REGISTRAR 256 REGISTRAR'S SIGNATURE VR A15 (4) 20 M 1/66 Miliantes Judge firme Catonsville, Md DATE



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 OF DEATH CERTIFICATE PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission o. COUNTY o. STATE b. COUNTY C LENGTH OF STAY IN 15 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest fown) outside corporate limits. and in ony event, within 72 hours of pegrest town-The low requires that the death certificate be executed within 24 hours NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS IS RESIDENC ON A FARM? NO YES DATE 3. NAME OF Middle Month Dov Year corban campletely DECEASED OF 19 (Type or print) DEATH IF UNDER 24 HRS IF JNDER S SEX DATE OF PROTH 9. AGE (In years A COLOR OR RACE 7. MARRIED NEVER MARRIED remove lost-birthday Months Doys Hours WIDOWED K DIVORCED 10o JSUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12 CITIZEN OF WHAT or foreign country) COUNTRY during most of working life even if fetired INDUSTRY physicion o 14. MOTHER'S MAIDEN NAME 13 FATHER'S NAME cremation, or removal, 17. INFORMANT IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOPIAL SECURITY (Yes, no, or unknown) (If yes give wor or dotes of service) DORIS 2239 SOUTHLAND RY INTERVAL BETWEEN 18 CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c). ONSET AND DEATH fronsit PART | DEATH WAS CAUSED BY. IMMEDIATE CAUSE (o) signed by buriol tron DUE TO Conditions, if any, which gove rise to immediate couse (a). DUE TO stoting the underlying couse Poge 4 may be retained by the hospital or attending this certificate has been 3 should be detached for use as the with the State Dept. of Health prior to WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) YES NO 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of Item 18) 200 ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20e PLACE OF INJURY (Home, form, (City or town) (Stote) 20c. TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED (County) factory, street, office bldg., etc.) Not While OR ATTENDING of work at work 21. 1 certify that (1) (this haspital) attended the deceased from 11-11-6 Cto 11-116 19 19____, that (I) (we) last saw the deceased alive an_ 11-607.19 _, and that death accurred at 6 M, fram causes and an the date stated above. DIRECTOR: 22b. DATE SIGNED 220. SIGNATURE MED. DIRECTOR 冈 M.D PHYS PHYS 22d. ADDRESS PHYSICIAN'S O HOSPITAL director, 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (Stote) 230 BURIAL, CREMATION, 23b. DATE THEREOF (County) SURIAL (Specify) LORRAINE ADDRESS BALTO 9 2Sb REGISTRAR'S SIGNATURE REC D BY REGISTRAR 24. FUNERAL DIRECTOR ANSBURY 64/1WINDSOR MILL DATEN 25M 1/67/



MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MACYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission e. COUNTY n. STATE h COLINTY Anne Arundel MARYLAND Maryland Anne Arundel C. CITY OR TOWN (If outside corporate limits, write RURAL and give negrest town, b. CITY OR TOWN of outs de corporate limits. c. LENGTH OF STAY N 16 write RURAL and give neerest town? Glen Burnie Severn d. NAME OF HOSPITAL OR INSTITUTION (if not an hospital, give street eddress) e. IS RESIDENCE ON A FARM? YES NO North Arundel Hospital 3. NAME OF DECEASED Month (Type or p,int) DEATH Anna Lange 19 67 6 COLOR OR RACE 5. SEX DATE OF BIRTH 7. MARRIED NEVER MARRIED AGE IIn yours | IF UNDER 1 YEAR IF UNDER 24 HRS last birthdey) Months Devs Hours female Nov. 30.1889 caus. WIDOWED IS 10a. USUAL OCCUPATION (Give kind of work 106 KIND OF BUSINESS OR INDUSTRY 11. B.RTHPLACE (State or fore on country) 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) ret. salescherk Stationary Store Germany Germany 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Hector Friederich Schaus 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17 INFORMANT Address (Yas, no, or unkown) - (If yes give wer or dates of service Mrs. Hilde McIntyre same as #2 above 18. CAUSE OF DEATH [Enter only one cause per line for (e) (b), and (c)] INTERVAL BETWEEN ONSET AND BEATH PART I. DEATH WAS CAUSED BY: in pencil IMMEDIATE CAUSE (e) DUE TO Conditions, if any, which gave rise to Immediate cause DUE TO as (a), steting the underlying cause lest. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e) 19. WAS AUTOPSY CERTIFICATION burial PERFORMED? NO DO 2Do. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURED, (Enter neture of in any in Pert I or Pert I, of item 18.) PRIMARY | or CONTRIBUTING | CAUSE OF DEATH. (2) MEDICAL b 20c. TIME OF INJURY Month, Day, Year 20d NJURY OCCURRED 2De PLACE OF INJURY (Home, form, 2Df. (City or fown) (County) (State) fectory, street, office bldg., etc.) Hour a.m. Whie Not While of work et work 21. I certify that I took charge of the remains described above, held an Autopsy ... Inspection death resulted from Natural causes Accident Suic'de designaf Homicide Undetermined manner DIREC CHIEF MEDICAL EXAMINER ACTUAL should be ...
FUNERAL ASSISTANT MEDICAL EXAMINER DATE SIGNED SIGNATURE DEPUTY MEDICAL EXAMINERY EXAMINER'S NAME (Type) Address (Street, city, town, or county) 22a, BURIAL, CREMATION. 226 DATE THEREOF 22c, NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, fown, or country) REMOVAL (Specify) <u>g</u> 40 ± Epiphany Cemetery Buria Odenton Anne Arundel 248 REC'D BY REGISTRAR | 246, REGISTRAR'S SIGNATURE YR A15ME Annapolis, Md. 5M 1/62

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11,844 CERTIFICATE OF DEATH 14852 PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death 2 USUAL RESIDENCE (Where deceased lived, if institution Resigence before admission) PLACE OF DEATH deat a. COLINTY o. STATE b. COUNTY MARYLANO b. CTY OR TOWN (If autside carparate limits, CLENGTH OF STAY IN 16 c CITY OR TOWN (I guisside corporate limits, write RURAL and give negrest town) write RURAL and give nearest town) North Shore d NAME OF HOSPITAL OR INSTITUT ON (If not in haspital, give street address) d STREET ADDRESS e IS RESIDENCE ON A FARM? 377 Dutchship 377 DutcHShip pape NO 🚾 3 NAME OF DECEASED 4 DATE First Middle Month Day Year STEVEN 11-22-LEUINSKI (Type or print) DEATH S SEX 6 COLOR OR RACE 7 MARRIED DATE OF BIRTH 9. AGE (n years F UNDER 1 YEAR ...NDFR 24 HRS NEVER MARRIED last birthagy) March 23, 1885 WIDOWED D VORCED 10a USJAL OCCUPATION (Give kind of work dane 11 BIRTHPLACE (County & State, or foreign country) TOP KIND OF BUSINESS OR 12 CITIZEN OF WHAT during poest of Marking life, even if retired) **NDUSTRY** COUNTRY ? 12tired 14 MOTHER'S MAIDEN NAME 13 FATHER'S NAME crematian, ar remayal, 15 WAS DECEASED EVER IN L.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT (Yes, ga, or unknown) (if yes give war or dates of service) worth Shore Ald Mosey HIGH 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) INTERVAL BETWEEN fransit PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (a) þ DUE TO signed Conditions, if ony, which gove rise ta immediate cause (a), DUE TO. stating the underlying cause State Dept. of Health prior to as the lost 19 WAS AUTOPSY PERFORMED? has PART II OTHER SIGNIFICANT CONDITIONS CONTR BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(g) 2 72-276 NO certificate 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port or Port II of item 18) 20a ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20e PLACE OF INJURY (Hame, form, (City or town) 20c TIME OF INJURY Marth Doy, Year 20d INJURY OCCURRED (County) (State) Hour am factory, street, office blda, etc.) at work 21 | certify that (1) (thus hospital) attended the deceased fram. 2-2-. 1967, that (I) (we) last saw the deceased alive an 11/17 1967, and that death accurred at left M, from causes and an the date stated above. 220 SIGNATURE 225 DATE SLØNED MED OIRECTOR ATTENDING M.D PHYS 22d. ADDRESS 22c. PHYSICIAN S director, pur O FUNERAL NAME (Type) 3708 Moren 23c NAME OF CEMETERY OR CREMATORY BUR AL CREMATION. 23d LOCATION (City or Town) (County) REMOVAL (Specify) REC O BY REGISTRAR OV 2 7 196 25b REGISTRAR S SIGNATURE VR A15 (4) 25M 1/67



FOR STATE

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DEPARTMENT

y delay is and 3 to -PHY-Poge

necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form

TO DEPUTY MEDICAL EXAMINER:

5 may be retained far your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages land 2 with the State

VR A15ME (\$)/

Health prior to burial, cremation, or removal, and in any event within 72 hours offer death

This certificate should be executed within 24 hours ofter deoth 16

148	40	MED	ICAL EXAMINE	R'S	CERTIFICATE O	F DEATH	1	1	485	3 3		
1. PLACE OF DEATH 0. COUNTY Anne A	rundel		MARYLA	IND	2. USUAL RESIDENCE (V o. STATE Maryland		lived, if institut b. COUN		e before	odmissio	on)	
b CITY DR TDWN (If outside corporate limits, c LENGTH OF STAY IN 16					c. CITY OR TDWN (If outside corporate limits, write RDRAL and give nearest town)							
write RURAL and give nearest town)					Baltimor	e			57.16			
d NAME OF HOSPI	TAL DR INSTITUTION (If n	ot in haspital, g		d STREET ADDRESS				e IS RESIDENCE ON A FARM?				
North A	rundel Hosp	ital			3606 West	Bay A	venue		Y		NO 🗌	
3 NAME OF First			Middle		Lost	4 DATE	Mont	h Doy Year			OI.	
(Type or print)	CAL	VIN	(nmi)		LIDIE, Jr.	OF DEATH	Novemb	oer	27,	19	67	
5 SEX	6 COLOR OR RACE	7 MARRIED	NEVER MARRIED		DATE OF BIRTH	9	AGE (In years lost birthdoy)	1F UNDER 1		IF UNDER		
Male	White	WIDOWED	DIVORCED		pril 21, 19	23	44 yrs	Monns	Days	HOURS	Min	
	N (G ve kind of work done		ND OF BUSINESS OR		11 BIRTHPLACE (Stote		ntry)		ZEN OF			
during most of working life, even if retired) Laborer Steel Industry Frederick County. Md. U-0-16								S. 1	A. e			
13 FATHER'S NAME					14 MOTHER'S MAIDEN I							
Calvi	n Lidie , S	r.			Margare	t Lidi	e					
15 WAS DECEASED EV	ER IN U.S. ARMED FORCES?	16	SOCIAL SECURITY NO	17 1	NFORMANT		Addre	iss				
Yes	W.W.#2	217	7 16 2548	Mrs	. Naomi Lid	ie,Rt.	2.Frede	erick.	Mar	ryla	nd	
1B CAUSE OF D	EATH (Enter only one co	use per ine for	(o), (b), ond (c).)						INTER	EVAL BET	TWEEN	
PART I. DEATH WAS CAUSED BY: ONSET AN ONSET AN									ET AND E	ЖДІН		
1 411		10										
Conditions, if on		(b)										
nse to immedia stating the unde		TO										
lost)	(c)							<u></u>			
PART II OTHER S	GNIFICANT COND TIONS	ONTRIBUTING T	O DEATH BUT NOT RELAT	ED TO T	HE TERMINAL DISEASE CON	IDITION GIVEN	N PART 1(o)			WAS AUTO		
A¥IO									YES		NO G	
200. EXTERNAL C. PRIMARY D'O'CC		20b. DE	SCRIBE HOW INJURY OCC	URRED (Enter noture of injury in	Port I or Port	I of item 1B.)	shot	dur			
	DN1KIBUTING 🗀	an	apparent a	tter	npted robber	rv		SHOC	aur	TILE		
	URY Month, Doy, Year	20d IN	IJURY DCCURRED 2	Oe. PLAC	E OF INJURY (Home, farm	20f	(City or town)	(Cou	nty)		(Stote)	
5:30 p	22 (02	67 While	Not While XX	focto	ory, street, office bldg , etc) 【nn		At	nne Ar	unde	e1. i	Md.	
			nains described aba	ve he		Inspection		iry 🔲,			apiniar	
1 1	ted fram: Natur				de . Hamicide		determined m		1	,	орина	
	1. 4.		J. \	7010	CHIEF MEDICAL	- Indiana Control						
ACTUAL SIGNATURE	Alleman 1	ヘ・フ。	20-		M.D. ASSISTANT MED	ICAL EXAMINER	X		22	2. DATE	SIGNED	
EXAMINER'S	Morano II	Contact	M D		DEPUTY MEDICA	AL EXAMINER			11	L/27	/67	
NAME (Type)	Werner U.	Phres	M.D.		Address (Street	, city, town, o	county)					
230 BURIAL CREMATI	1		23c NAME OF CEMETE			23d LOC/	ATION (City or To	wn)	(County)	(5	Stote)	
REMBYAL Specif	Dec. 1	, 1967	Mount Oliv	/et		Fred	erick, M	aryla	nd			
24. FUNERAL DIRECTO	OR Noule	11-	M. ADDRESS	de		BY REGISTRA	R 2Sb RE	G STRAR'S SI	GNATURE	uda	Pur.	
M. R.	Etchison &	Son.	Eredeniek			0.1	1967 /	many (-0 A	0		

M. R. Etchison & Son, Frederick, Maryland DATEDEC 1



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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4 4 4 6 T	1 5	LACE OF DEATH				II o negati	DECEMBER A	ngt	F 1 f		befare admission)
death.		. COUNTY				o, STA		where deceased	b. COL		setare admission)
offer after			Anne Arundel		MARYLAND		Mary	land			
	Ь	CITY OR TOWN (f auts de carparate limits, I give nearest town)		L LENGTH OF STAY IN 16	c CITY O	R TOWN (IF ou	iside carparate	limits, write RL	JRAL and give m	tarest fown)
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		Crownsy	rille				Bal+	imore			34-11
24 hours	d	NAME OF HOSPIT	AL OR INSTITUTION (If not in	haspital, give	street address)	d STREET	ADDRESS	TIMOT C			P S RESIDENCE ON A FARM?
filled pop pop thin 7		Charman	ville State H		٦	0-	10 TI	0.1	1		YES NO 🔀
hin 2 filled pap thin	3 1	AME OF	First	OSDILB	Middle	Lo		wStree	E. Mar		
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ed car	5 5		Ado		G.	Mark		DEATH	101/1		5 196/
ev ev	2 3	EA		MARRIED _	NEVER MARRIED	8. DATE OF	RIKIM		AGE (In years last birthday)		AR I FUNDER 24 HRS
d c mo		M	W	VIDOWED _	.] DIVORCED [8/20	1/84		33 Yrs		1 11000
ate be exercian and a	100	JSUAL OCCUPATION	(Give kind of wark dane		OF BUSINESS OR	11. BIRTH	PLACE (County	& State, ar foreig	in conntry)		N OF WHAT
icate b /sician please if, and i	UUM	I Tara A A A	life, even if retired)	FA	ENTRICAL		German	ar.		COUNT	11.514.
) Si	13.	FATHER'S NAME	W. C.L. C.	_l_dente for the	ب مرد مناكره إمرام اساط كالواطنة	14 MOTH	ER'S MAIDEN N	TAME		1	211111
phy oval		12-1- N	r1								
en E	15	Adolf N WAS DECEASED EVE	R IN U.S. ARMED FORCES?	16 506	IAL SECURITY NO. 17.	INFORMANT	igusta.		Addi	racc	
he death ce attending permit. The ran, ar remo	(Yes	, na, ar ynknawn)	(If yes give war ar dates af ser	vice)							
e do de	H	1.C				dospit	al Reco	ords, C	rownsv:	ille, Ma	
equires that the death certificate be executed within physician. signed by the attending physician and campletely fille burial-transit permit. Then please remave carbon paburial, crematian, ar removal, and in any event, within		18 CAUSE OF DE	ATH (Enter only one cause p IH WAS CAUSED BY:								NTERVAL BETWEEN ONSET AND DEATH
that then the an. by the transit cremat		11.00	IMMEDIATE CAUSE (a)		Pneumonia_						OTTOC I AID DEATH
		473	DUE TO							1	
urre hysid igner urral		Conditions, if any,	which gave) (b)_								
Par is a par		stoting the under									
ding ding een the ir to		last.) (c)								
The low requires attending physici has been signed se as the burial-th priar to burial.	1_1	PART II OTHER 5H	GNIFICANT CONDITIONS CONTS	RIBUTING TO	DEATH BUT NOT RELATED TO	THE TERMINA	AL D SEASE CON	DITION GIVEN	N PART 1(a)		19 WAS AUTOPSY PERFORMED?
Handse T	CATION				-				(-)		PERFORMED?
IAN: That of or at ficate ho far use Health	Z.	200 ACCIDENT WAS	nic Brain Syr	larome	B) Hernia U	MDITIC	8.1	Doub Los Doub H	-K-A 10-1		1E3 [] MO [3
Partie de la CEA	CERTIF	OR CONTRIBUTING	CAUSE OF DEATH	ZOU. DENCK	IDE ROW HOOK! OCCURNED	(Emer natur	e or requey in	ran i ai rasi d	di lietti ib)		
YS ask			MEDICAL EXAMINER)					-			
PHY he ha this o letach e Dept	MEDICAL	20c TIME OF INJU Haurian	IRY Manth, Day, Year n.	20d INJU While			Y (Hame, form ffice bldg., etc.)		(ty ar town)	(Caunty	(State)
	≥	p.n	10	at wark		(10) 1 111001, 0	11110 810 91, 210.)				
ATTENDING stained by the CTOR: After shauld be d		21 Certif	ly that (I) (this hispita) attended	the deceased fram_	8/1	,1	967_, ta_	11/25	, 1967.	, that (I) (we) la
R ATTENI retained ECTOR: / B shauld with the		saw the de	eceased alive on 11	/25	19 <u>67</u> , and th	at death a	ccurred at	4:15 M,	fram causes	and an the	date stated abov
FSECTER		22a SIGNATURE	11/11/11	11.11		4777110	4440	p p	CTAFF	22b. DATE	SIGNED
Mary Control			11/11/11	wil	N	ATTEND D PHYS	ING	MED DIRECTOR	IX PHYS.	11/2	5/67
, - -		22c PHYSICIAN'S	VI	-		22d.	ADDRESS				2181
RA De De De		NAME (Type)	Ludwig Bene	edict.	M.D.	C	rownsv	ille St	ate Ho:	spital.	Maryland
TO HOSPITAL Page 4 may TO FUNERAL director, pag shauld be fi	23 0	BURIAL, CREMATIC	IN. 23b DATE THEREO		23 NAME OF CEMETERY OF				TION (City or To	-	unity) (Stote)
Page O FUN direct shaul	L	REMOVAL (Specify)	11-25-1	17	# TT	LUFI	F (ZIM		MIDOL		MID
5 5 6	24	FUNERAL DIRECTO			ADDRESS	LUM		BY REGISTRAR			ATURE
VR A15 (4)		TOREGOL DIRECTO		15	ADDRESS		Ziu KECU		A'9 230 K	EGISTRAR S, SIGN	Constanting .



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14855 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1 PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o. COUNTY n STATE b. COUNTY Page KANAXXXX Anne Arundel MARYLAND Maryland Anne Arundel

c CITY OR TOWN (It outs de corporate limits write Rukal and give necrest town) delay b CTY OR TOWN iff outside corporate I mits, C .ENGTH OF STAY N 16 write RJRAL and give nearest town) Annapolis
d. STREET ADDRESS Depay Annacolis d NAME OF HOSPITAL OR INSTITUT ON (If not in hospital, give street address) B IS RESIDENCE ON A FARM? NO + 37 Oak Court in pencif in Item 18 Give Pages 37 Oak Court Sta alang with 3 NAME OF Firs1 4. DATE Month Middle White Word DECEASED Martin (Type or pnnthKA Ward DEATH November White Martin AGE (In years IF LNDER 1 YEAR 6 COLOR OR RACE 7 MARR ED NEVER MARRIED lost birthdoy) Months Dovs ile pages 1 and 2 w hours after death. Caus. male WIDOWED DIVORCED June 28,1926 10a. USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (State or foreign country) 12 CITIZEN DE WHAT during most of working life, even if retired)
Supervisor INDUSTRY COUNTRY? Plastics Rose Hill Va. U SA 13 FATHER'S NAME John H. Martin Nanwy Hopkins 15 WAS DECEASED EVER IN U.S. ARMED FORCES? event within 72 16. SOCIAL SECURITY NO. 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dotes of service) 227-24-7111 Mrs. L. Fern Martin - same as #2 above ves IB CAUSE OF DEATH (Enter on y one couse per line for (a), (b), and (c) NTERVAL BETWEEN ONSET-AND DEATH PART I DEATH WAS CAUSED BY .MMED.ATE CAUSE (o) DUE TO Conditions, if any, which gave (b) rise to immediate couse (a). DUE TO stoting the underlying couse PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a) 19 WAS AUTOPS ar remayal, PERFORMED? NO P pe 4 should be 200 EXTERNA, CAUSE WAS PRIMARY OF CONTRIBUTING 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Portal or Port II of item 18) 3 should CAUSE OF DEATH 20e PLACE OF NJURY (Mome form, 20c. TIME OF INJURY Month, Doy, Year 20d NJURY OCCURRED factory, street office bldg , etc.) YOUR Not While ot work of work 21. I certify that I took charge of the remains described obove held an Autopsy Inspection . Inquiry and in my apinion death resulted fram Notatal causes Undetermined monner Suicide Hamic de CHIEF MEDICAL EXAMINER Health prior to ACTUAL 22. DATE SIGNED ASSISTANT MEDICAL EXAMINER SIG NATURE FUNERAL DEPUTY MEDICAL EXAMINER EXAMINER'S NAME (Type) Address (Street, city town of county) 23c NAME OF CEMFTERY OR CREMATORY 23d LCCA ON City of Town 230 BUR AL CREMATION. 0 12/4/67 Hillcrest Cemetery Annapolis 250 REC'D BY REGISTRAR 255 REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR VR A15ME (5) FUNERAL HOME * MNAPO 6M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1. MARYLAND CERTIFICATE OF DEATH death. 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) PLACE OF DEATH ANNE ARUNDEL b. CAUNTE ARUNDEL a. STATE MARYLAND after MARYI AND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) C. LENGTH OF STAY IN 1b b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town MD hours 42 min Ft Geo G. Meade. Maryland d. STREET ADDRESS e. IS RESIDENCE d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DN A FARM? 7341-C Creed Court Kimbrough Army Hospital NO X YES rand completely free remove carbon por any event, within withii executed within Month NAME DE DECEASED DATE Middle Mc Clarnon. Infant Male 67 November DEATH 19 (Type or print) AGE (In years | IF UNDER 1 YEAR IF UNDER 24 HRS 6. COLOR OR RACE | 7. MARRIED | NEVER MARRIED DATE OF BIRTH 5. SEX last birthday) | Months | Days Hours 4 Nov 67 Male Can WIDDWED DIVDRCED (nding physician are. Then please re-removal, and in a 10a. USUAL OCCUPATION (Give kind of workdone during most of working life, even if retired)

N/A

10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY? that the death certificate be Anne Arundel, Maryland USA 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME has been signed by the attending plas the burial-transit permit. Then prior to burial, cremation, or remova Carol J. Collongs Terry L. Mc Clarnon 17. INFORMANT Address 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, or unkown) (If yes give war or dates of service)

N/A

N/A Terry E. Mc Clarnon(f) Same as INTERVAL BETWEEN 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c), 1 ONSET AND DEATH PART I. DEATH WAS CAUSED BY: Pulmonary hypoplasia and Atelectasis the hospital or attending physician. IMMEDIATE CAUSE (a) DUE TO The law requires Conditions, if any, which (b) gave rise to immediate DUE TO cause (a), stating the underlying cause last. certificate has CERTIFICATION PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTDPSY of Health use PERFORMED? YES X ND PHYSICIAN: DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part 1 or Part II of Item 18.) 20a. ACCIDENT WAS UNDERLYING I OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MIIDICAL 20f. (City or town) (County) (State) 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc. Hour a.m. While - Not While After be retained by at work ATTENDING at work 21. I certify that (6) (this hospital) attended the deceased from 4 Nov 4 Nov that 40 (we) last DIRECTOR: 19_____, and that death occurred at 1:46M, from the causes and on the date stated above. saw the deceased alive on 4 Nov 67 22p., DATE SIGNED 22a. SIGNATURE 4Movember 67 director, page 3 should be filed y ATTENDING DIRECTOR M.D. PHYS. PHYS. FUNERAL D 22. PHYSICIAN'S 22d. ADDR ESS ROPARTIVE Kimbrough AH, Ft Geo G. Meade, Md. CULLEN. (State) AME OF CEMETERY OR CREMATORY LOCATION (City, town or county) BURIAL, CREMATION, 23b. 2 REGISTRAR'S SIGNATURE FUNERAL DIRECTOR ADDRES Milianlas 15M 4-64



DIVISION OF STATISTICAL RESEARCH PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH 14849 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where decessed lived, If institution: Residence before admission) a. COUNTY e. STATE b. COUNTY death MARYLAND by the b. CITY OR TOWN (if outside corporate limits. c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give negrest town) filled in Pages 1 hours after completely filled d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d. STREET ADDRESS S RESIDENCE ON A FARM? papers. NO V YES [72 3. NAME OF First Middia 4. DATE Yaer Month Dev DECEASED OF within (Type or print) DEATH 19 carbon COLOR OR RACE TO MARRIED THE NEVER MARRIED 5. SEX pue 9. AGE (In years | IF UNDER I YEAR IF UNDER 24 HRS last birthday) event Months House death certificate WIDOWED [DIVORCED physician гелоуе 10s. USUAL OCCUPATION (Give kind of work 10b. KIND OF BUSINESS OR INDUSTR or foreign country) 12. CITIZEN OF WHAT COUNTRY done during most of working life, avan if retired) Su y please .= 13. FATHER'S NAME S MAIDEN NAME affending and NOOLFH Then requires that the 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Addresi (Yes, no. or unkown) | (If yes give war or detes of sarvice) signed by 18. CAUSE OF DEATH [Enter only one cause per line for (e) INTERVAL BETWEEN ò ONSET AND DEATH PART I. DEATH WAS CAUSED BY: cremation. IMMEDIATE CAUSE (a) burial-transit DUE TO altending adent Carenno Conditions, if any, which gava rise lo immadiale cause has DUE TO (a), sleting the underlying the b ceuse last. 2: After this certificate detached for use as the the hospital PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(1) 19. WAS AUTOPSY 0 CERTIFICATION PERFORMED? prior NO F 200 ACCIDENT WAS UNDERLYING I 20b. DESCRIBE HOW INJURY OCCURRED. (Enter neture of injury in Pert I or Pert II of item 18.) Health OR CONTRIBUTING IT CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) be retained by 20c. TIME OF INJURY Month, Day, Yaer 20d. INJURY OCCURRED | 20e, PLACE OF INJURY (Home, farm, ! 20f. (City or town) (County) (Stelle) ŏ factory, street, office bldg., atc.) Hour a.m. While Not While DIRECTOR: Dept. at work 19 at work p.m. pe 21. I certify that (I) (this hospital) attended the deceased from..... plnods State M, from the causes and on the date stated above. saw the deceased alive on... ТаУ .f.., and that death occurred at 22e, SIGNATURE 22b. DATE TO FUNERAL 1 director, page 3 ATTENDING SIGNED STAFF HOSPITAL DIRECTOR PHYS. PHYS. M.D. 22c. PHYSICIAN'S 22d, ADDRESS NAME (TypBarber C. Palmer Jr. Cathedral St. Annapolis, Maryland M.D. 23a. BURIAL, CREMATION, | 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d, LOCATION (City, town or county) (State) REMOVAL (Specify) REMATION 24 FUNERAL DIRECTOR'S SIGNATURE 25a. REC'D BY REGISTRAR 25Ь. REGISTRAR'S SIGNATURE **ADDRESS** VR A15 (4) 20M 5-63



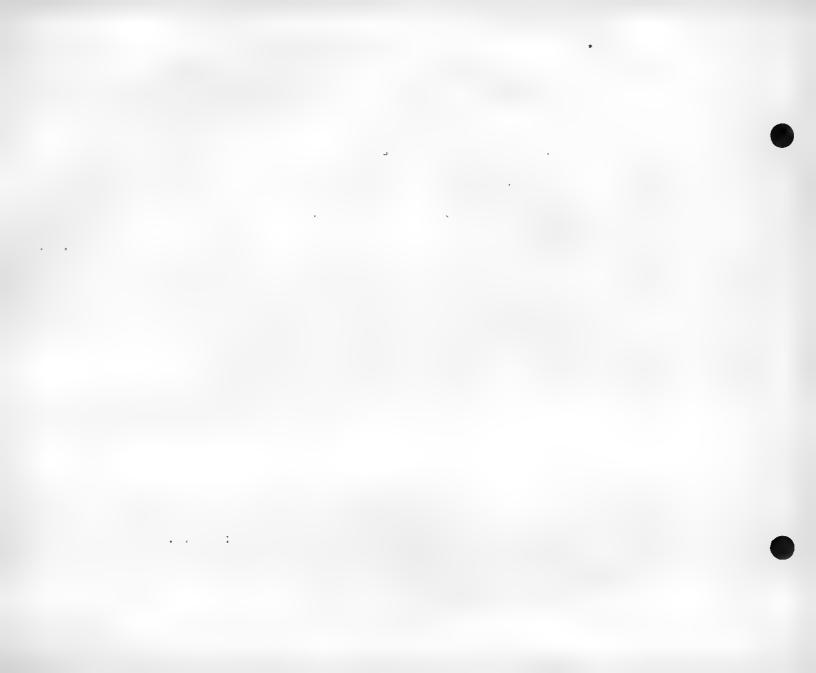
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14858 CERTIFICATE OF DEATH OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. I. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceosed lived, if institution Residence before admission) a. COUNTY o. STATE b. COUNTY Anne Arundel MARYLAND Maryland b. CITY OR TOWN (If outside corporate +mits, write RURAL and give nearest tawn) CLENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate imits, write RURAL and give nearest town) 21061 Crownsville 2 mon Ferndare d NAME OF HOSPITAL OR (NSTITUTION (If not in hospital, give street address) d STREET ADDRESS e IS RES DENCE ON A FARM? paper Crownsville State Hospital within N. Hollins Ferry Road YES NO F NAME OF carban 4 DATE 1ast Dov Year DECEASED (Type or print) Nemethyargo DEATH Antol S SEX 6. COLOR OR RACE B. DATE OF BIRTH 9 AGE (in years IF UNDER 1 YEAR IF UNDER 24 HRS 7 MARRIED NEVER MARRIED Jost birthdov) Months Dovs Hours and in any DIVORCED 2/16/87 gud 100 _SUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State or foreign country) 12 CITIZEN OF WHAT during most of working life, even fret'red) COUNTRY? INDUSTRY Carpenter None Hungary USA 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME or remayal, Address Address Ι Unknown IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16 SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dotes of service) Hospital Records, Crownsville, Maryland 213-12-3550A unknown crematian, 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN burial-transit PART I. DEATH WAS CAUSED BY ONSET AND DEATH Arteriosclerosic Heart Disease IMMEDIATE CAUSE (o) DUE TO signed ! Conditions, if any, which gave generalized Atherosclerosis ase to immediate couse (o), DUE TO as been as the priar tal stating the underlying couse aftending last PART I OTHER SIGNIFICANT CONDITIONS CONTRIB. TING TO DEATH BUT NOT RELATED TO THE TERMINA. DISEASE CONDITION GIVEN IN PART I(o) 19 WAS AUTOPSY PERFORMED? has NO Urinary Tract Infection. Uremia Decubitus ulcers 200 ACCIDENT WAS .. NDERLYING 20b DESCR BE HOW INJURY OCCURRED (Enter noture of injury in Port or Port II of Item 18) OR CONTRIBUTING CI CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, 20c. TIME OF NJURY Month, Doy, Year (City or town) (County) (Stote) Hour om loctory, street, office bldg, etc.) Not While ot work 21 | certify that (1) (this naspital) attended the deceased from 9/13 1967 to 11/29/ Page 4 may be retained FUNERAL DIRECTOR: 19.67, and that death accurred at 0.00 M, from causes and on the date stated above saw the deceased alive on 220 SIGNATURE 22b DATE SIGNED ATTENDING M D 11/29/67 DIRECTOR لهجا PHYS director, page 3 shauld be filed PHYS 22d ADDRESS 22c. PHYSICIAN'S NAME (Type) Benedict. M.D. Crownsville State Hospital 23d .OCATION (City or Town) 23b DATE THEREOF NAME OF CEMETERY OR CREMATORY 230 BUR AL CREMATION Maryland (Stote Meadowridge Memorial Park
ADDRESS 21225 250 RECD BY 0 24 FUNERAL DIRECTOR 250 RECD BY REGISTRAR 2Sb REGISTRAR'S SIGNATURE DATE DEC 237 Patapaco Ave. 25M 1/67



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14851 14859 CERTIFICATE OF DEATH The law requires that the death certificate be executed within 24 hours after death 2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) PLACE OF DEATH · COUNTYANNE ARUNDEL O STATE MARYTAND 6 COUNTY ANNE ARUNDEL MARYLAND c LENGTH OF STAY IN 16 b CITY OR TOWN (If outside corporate limits, c CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) FIWIGENACIONEADE, MARYLAND DAVIDSONSVILLE 12 days e IS RESIDENCE ON A FARM? d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS 312 KING MANOR KIMBROUGH ARMY HOSPITAL NO 🔼 NAME OF Middle 4. DATE pou-Yegr 1967 W l ost DECEASED November **EMMA** NEUGEBAUER (Type or print) DEATH event. IF UNDER 1 YEAR IF UNDER 24 HRS DATE OF BIRTH 9 AGE (In years 6 COLOR OR RACE 7 MARRIED NEVER MARRIED 8 dast birthdoy) Months Days Hours 11 FEB 1882 F Cau ond in any WIDOWED K DIVORCED ond 12. CIT ZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) GERMAN during most of working life, even if retired) GERMANY 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME or remayal. UNKNOWN THOMAS JAWORSKI 17. INFORMANT IS. WAS DECEASED EVER IN L.S. ARMED FORCES? 16 SOCIAL SECURITY NO (Yes, no, or unknown) (If yes,give wor or dotes of service) (D) Same as # EDELITRAUD JAMES NONE 00, INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) signed by the burial-tronsit PART I. DEATH WAS CAUSED BY: ONSET AND DEATH IMMEDIATE CAUSE (o) **DUE TO** HINKNOWN buriol. Conditions, if ony, which gove (b) rise to immediate couse (a), DUE TO stoting the underlying couse WAS AUTOPS'
PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINA. D SEASE CONDITION GIVEN IN PART 1(o) YES X №0 OR ATTENDING PHYSICIAN: 20b DESCRIBE HOW INJURY OCCURRED (Enter notice of injury in Port I or Port II of item 18) 20g ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH detached (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20e PLACE OF INJURY (Home, form, 20f (City or fown) (State) 20d. INJURY OCCURRED (County) 2Gr. T.ME OF INJURY Month, Day, Year Hour o.m. foctory, street, office bldg., etc.) While Not While ot work of work 1025 NOV 21. I certify that (2) (this haspital) attended the deceased from 13 Nov and that death occurred at \$250 M, fram causes and on the date stated above saw the deceased alive an 25 Nov TO FUNERAL DIRECTOR: 220. SIGNATURE 22½ DATE SIGNED STAFF M.D director, page ; FGGMMD 22c PHYSICIAN S NAME (Type) 23c. NAME OF CEMETERY OR CREMATORY 23o BURIAL CREMATION. 23b DATE THEREOF 23d. LOCATION (City or Town) REMOVAL (Specify) Our Lady of Sorrows Owensville 2SO REC'D BY REGISTRAR REGISTRAR S SIGNATUR Hopping 25M 1/67 HOPPING FUNERAL HOME



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 74852 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 haurs after death. I. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. COUNTY o. STATE b. COUNTY Anne Arundel Maryland MARYLAND Anne Arunde l b CITY OR TOWN (If outside corporate imits, c LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town) Bristol 20728 Annapolis d NAME OF HDSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e S RESIDENCE ON A FARM? Anne Arundel General Hespital NO 😿 YES . campletely fi nove carban 3. NAME OF First Middle Lost 4. DATE Month Year DECEASED OF and in any event, Greenwell (Type or print) OWENS DEATH November AGE (In years last birthday) 5 SEX IF UNDER 1 YEAR F UNDER 24 HRS 6 COLOR OR RACE 7 MARRIED NEVER MARRIED 8 DATE OF BIRTH Months Dovs Hours February 10,1875 WIDOWED K DIVORCED White 100 USUAL OCCUPATION (Give kind of work done 106 KIND OF BUSINESS OR 11 RIRTHPLACE (County & State or foreign country) 12 CITIZEN OF WHAT during most of working life; even (f refired) CD JNTRY? INDESTRY Maryland Carpentel U. S. 13 FATHER S/NAME 14. MOTHER'S MAIDEN NAME burial, cremation, or removal, attending phy perm.t Then 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT (Yes, no, or unknown) (If yes give war or dates of service) CAUSE OF DEATH (Enter only one couse per hine for (o), (b)
PART DEATH WAS CAUSED BY NTERVAL BETWEE and (c). signed by the burial-tronsit p ONSET AND DEATH IMMEDIATE CAUSE (6) DUE TO Conditions, if ony, which gove rise to immediate couse (a). DUF TO stoting the underlying couse be detached far use as the State Dept. of Health prior to has been lost. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELAYED TO THE TERMINAL DISEASE CONDITION GIVEN N PART 1(6) PERFORMED? YES NO s certificate PHYSICIAN: 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of noury in Port I or Port II of tem 1B) 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20d INJURY OCCURRED 20e PLACE OF NJURY (Home, form, (City or town) (County) (Stote) TIME OF INJURY Month, Doy, Year O FUNERAL DIRECTOR: After th Hour o.m. foctory, street, office bldg., etc.) Not While ATTENDING at work 21. I certify that (1) (this hospital) attended the deceased fram TO HOSPITAL OR ATTEND Page 4 may be retained and that death accurred at saw the deceased alive an on the date stated above causes and 220 SIGNATURE 22h DATE SIGNED ATTENDING M.D PHYS DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) BURIAL, CREMATION, DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY LOCATION (City or Town) (County) (Stote REMOVAL (Specify) ne 2 12m26 24 FUNERAL DIRECTOR 2So RECD BY REGISTRAR REGISTRAR'S SIGNATURE



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14853 14560 CERTIFICATE OF DEATH and 2 death requires that the death certificate be executed within 24 haurs after death. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o COUNTY a. STATE b COUNTY Anne Arundel Maryland Anne Arundel urs after MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give necrest town)
Annapol is c LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURA, and give nearest town) Ha rwood lease remave carban papers and in any event, within 72 hi d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS Anne Arundel General Hospital Rt. 1, Box 140 YES remave carban 3 NAME OF Middle 4 DATE Month Doy Year DECEASED November OWENS 12 Henry (Type or print) James DEATH 19 S SEX 6 COLOR OR RACE IF JNDER 1 YEAR 7. MARRIED NEVER MARRIED 8 DATE OF BIRTH AGE (In years IF UNDER 24 HRS lost b rthdoy) Months Dovs Male WIDOWED DIVORCED 12, 1902 Negro. June guo 100 SUAL OCCUPATION (Give kind of work done 106 KIND OF BUSINESS OR 31 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT ease during most of working life even if retired). INDUSTRY COUNTRY? Maryland U. S. T3 FATHER S NAME 14. MOTHER'S MAIDEN NAME crematian, ar remayal, attending phy permit. Then I WAS DECEASED EVER IN U.S. ARMED FOR CESS 16 SOCIAL SECURITY NO INFORMANT permit. (Tes no oranknown) (If yes give wor or dotes of service CAUSE OF DEATH (Enter on y one couse per lime for (o), (b), and (c)) INTERVAL BETWEEN ONSET AND DEATH signed by the burial-transit p PART I, DEATH WAS CAUSED BY IMMEDIATE CAUSE for DUE TO Conditions, if ony, which gove rise to immediate couse (a), DUF TO stoting the underlying couse has been be detached for use as the state Dept. af Health prior ta lost. PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) 19 WAS AUTOPS)
PERFORMED? TO FUNERAL DIRECTOR: After this certificate NO 200 ACCIDENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF FITHER, NOTIFY MEDICAL EXAMINER 20c. TIME OF NIJRY Month, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home form, (City or town) Hour o.m Not While foctory, street, office bldg., etc.) TO HOSPITAL OR ATTENDING of work 21. I certify that (1) (this hospital) attended the deceased from director, page 3 shauld shauld be filed with the be retained saw the deceased alive an and that death accurred from causes and an the date stated above 22o. SIGNATURE 22b. DATE SIGNED M.D PHYS DIRECTOR PHYS. 22c. PHYSiCIAN'S 22d. ADDRESS NAME (Type) 230 BURIAL, CREMATION 23b DATE THEREOF OR CREMATORY OCATION (City of Town) (Rounty)

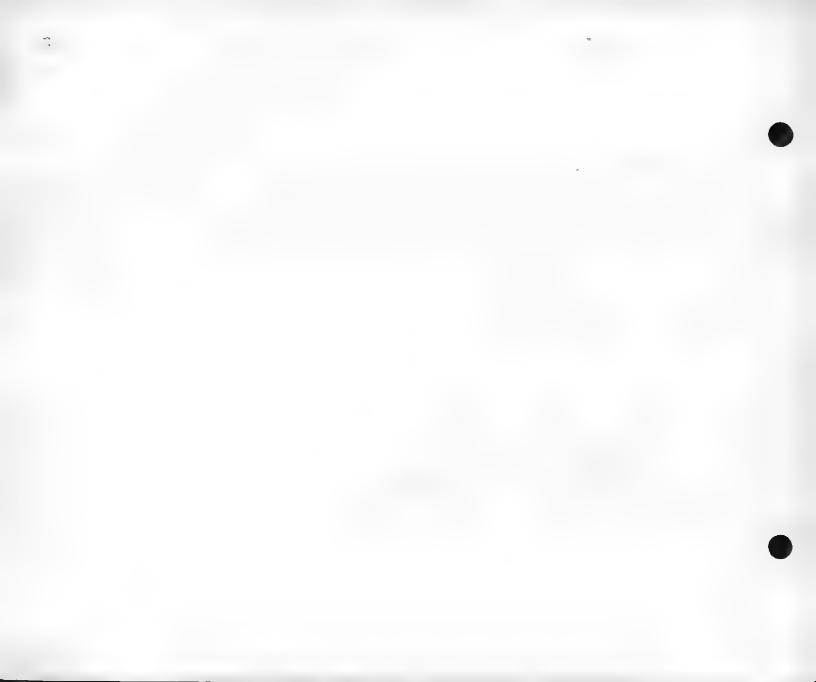


MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14254 CERTIFICATE OF DEATH 14.61 OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. death uneral 1 and 2. USUAL RESIDENCE (Where deceosed fived, if institution. Residence before odm. ssion) PLACE OF DEATH a. COUNTY o. STATE b. COUNTY St. Mary's Anne Arundel MARYLAND Maryland. b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Crownsville 25 days Colton d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS IS RESIDENCE ON A FARM? papers 'Rural Route YES NO EX burial, cremotion, or removal, oad in any event, within Crownsville State Hospital 3. NAME OF 4. DATE attending physicion and completely to sermit. Then please remove carbon Doy Yeor DECEASED (Type or print) DEATH Clarence Herbert Ps.1 mer F UNDER 1 YEAR S. SEX 6 COLOR OR RACE B. DATE OF BIRTH AGE (In years IF UNDER 24 HRS 7 MARRIED NEVER MARRIED Months inday) Doys Hours Nov. 27. DIVORCED Male White 11 B RTHPLACE (County & State or foreign country) 10o. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR 12 CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? Ret. Tavern Owner -Self-Employed Washington D.C. USA Mary J. Sherwood William H. Palmer 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT permit. (Yes, no, or unknown) (If yes give wor or dotes of service 577-09-9069 | Hospital Records, Crownsville, Maryland 18 CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c))
PART I, DEATH WAS CAUSED BY INTERVAL BETWEEN Arteriosclerosis Heart Disease burial-transit ONSET AND DEATH Acute pulmonary edema IMMEDIATE CAUSE (o) O HOSPITAL OR ATTENDING PHYSICIAN: The low requires the Page 4 may be retained by the hospital or attending physiaan. DUE TO Conditions, if any, which gave Generalized Atherosclerosis rise to immediate couse (a), **BUE TO** stoting the underlying cause OF UNERAL DIRECTOR: After this certificate has been director, page 3 should be detached for use as the should be filed with the State Dept. of Health prior to PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o) 19 WAS AUTOPS Y PERFORMED? cirrhosis of liver s of right leg YES X NO F Hypertension, Diabetes Mellitus, Ulcer celluliti 200 ACCIDENT WAS UNDERLYING [20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port or Port 1 of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) B 20e PLACE OF INJURY (Home, form, 20c TIME OF NIURY Month, Day Year 20d INHIRY OCCURRED ((ty or town) (County) (Stote) MED Hour to.m. factory, street, office bldg, etc.) at work of work 21. I certify that (1) (this hospital) attended the deceased from..... 1967 to 11/29 _____. 19_67 that (I) (we) last 19.67, and that death occurred at 1.30 M, from causes and on the date stated above saw the deceased alive on 11/29 22o SIGNATURE 22b DATE SIGNED DIRECTOR M D 22d ADDRESS 22c. PHYSICIAN S NAME (Type) Ludwig Benedict Crownsville State Hospital, Maryland 23b. DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) 230 BUR AL CREMATION. (County) Bullet (Specify) P/G. Md. 12/4/67 Colmar Manor Ft. Lincoln 24. FUNERAL DIRECTOR ADDRESS 250 REC'D BY REGISTRAR 25b REGISTRAR S SIGNATURI ocharles & Francis Gasch's Sons Hyattsville, Md.



MARYLAND STATE DEPARTMENT OF HEALTH

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. 2		14255	CERTIFICAT	E OF DEATH	14862
funeral funeral	1 1	LACE OF DEATH-	MARYLAND	2 USUAL RESIDENCE (Where decease o. STATE	d lived, if institution. Residence before admission) b COUNTY
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filled in pages. hin 72 h		RAME OF HOSPITAL OR INSTITUTION III NO	wing Home	3 STREEL ADDRESS BEL	nche de la residence ON A FARM? YES NO
campletely ave carbah		AME OF ECEASED (ype or print)	roy par	Red OF DEATH	Mgnth Doy Year 1965
e executed with and campletely remave carbain any event, w		Rec agi	7 MARRIED NEVER MARRIED DIVORCED DIVORCED	9-30-1990-	AGE (In yeor's IF UNDER I YEAR IF UNDER 24 ARS loss by thday) Months Doys Hours Min
e death certificate be ex attending physician and permit. Then please rem an, ar removal, and in an	dur	USUTAL OCCUPATION (Give kind of work done g prost of warking life, even if refred) FATHER'S NAME	10b. KIND OF BUSINESS OR INDUSTRY	1] BIRTHRIACE (County & State, or fore	ign country) 12. CITIZEN OF WHAT
ng phys Then p		WAS DECEASED EVER IN L. S ARMED FORCES?	Parker 16. SOCIAL SECURITY NO 17	Children Martelle C	Collector 2
he death attendir permit. ian, ar re	(Ye	, no, or unknown) (If yes give wor or dates o	service)	larencepa	Kar & Cenrick
physician. physician. signed by the burial-transit p		nse to immediate couse (a), stating the underlying couse DUE	(b) Collection Collect	rulte Mary	Allaland Interval Between Onset and Death
HYSICIAN: The faw rithospiral ar attending is certificate has been tached far use as the lept, of Health priar ta	CATION		INTRIBUTING TO DEATH BUT NOT RELATED TO	THE TERMINAL DISEASE CONDITION GIVEN	IN PART (a) 19 WAS AUTOPSY PERFORMED? YES NO
	AL CERT F CATION	200 ACCIDENT WAS UNDER YING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		(Enter nature of injury in Port I or Port	· ·
by the hos tifer this ce be detache State Dept.	MEDICAL	20c TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19	While Not While of work of work	ctory, street, office bldg , etc.)	(City or town) (County) (State)
= 7 7 0		21. I certify that (I) (this hosp saw the excessed alive on	oited) oftended the deceased from_1967, and the	of death occurred of 4PM,	from couses and an the dote stated above
be 3 ed year		22c. PNASHOTAN'S NAME (Type)	ABenn M	D. ATTENDING DIRECTOR E	STAFF PHYS DIFFERENCE OF THE PHYS DIFFERENCE
TO HOSPITAL Page 4 may TO FUNERAL C director, pag shauld be fill	1	BURIAL, CREMATION, 23b. DATE THE	1967 Ftive	20 Est	ANON (City or Town) (County)) (Sport)
VIII A15 (4) 25M 1/67	24	FUNERAL DIRECTOR -	WH Chring	DANOV 7	967 Persistants signature

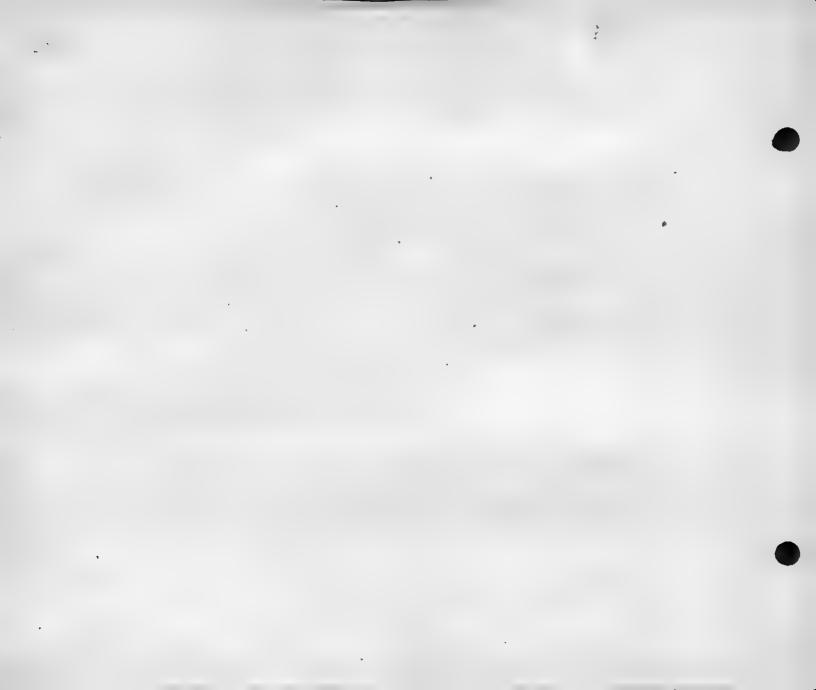




MARYLAND STATE DEPARTMENT OF HEALTH 14857 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14864 CERTIFICATE OF DEATH requires that the death certificate be executed within 24 hours after death and. PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) o. COUNTY o. STATE b. COUNTY Anne Arundel Maryland Anne Arundel MARYLAND b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. CPTY OR TOWN (If autside carparate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 Severna Park 5 days Annapolis d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS ON A FARM? 102 Riggs Ave., Anne Arundel General Hospital NO TX NAME OF Middle 4 DATE Manth Day Year (Caroline) DECEASED RALSTON November 67 Flagg **OEATH** remaye car IF UNDER 24 HRS S SEX 6. COLOR OR RACE DATE OF BIRTH AGE (In years 7 MARRIED NEVER MARRIED ast birthdov) Manths Haurs Sept. 5, 1888 Female White WIDOWED TO DIVORCED 10a USUAL OCCUPATION (Give kind of work dogs 106 KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT during most of working life, even if retired) COUNTRY? INDUSTRY Maryland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME burial, cremation, ar removal, William Flaggs Dmma ----1S. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown) (If yes give wor or dates of service) 16 SOCIAL SECURITY NO. Rulston Higgs Ave. - Severna Park, Md. INTERVAL BETWEEN IB. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c)
PART I. DEATH WAS CAUSED BY: signed by the buriol-transit p ONSET AND DEATH IMMEDIATE CAUSE (a) DUE TO Canditians, if any, which gave rise to immediate cause (a), DUE TO stating the underlying cause priar ta PART H. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NAC DISEASE 19 WAS AUTOPS)
PERFORMED? be detached for use State Dept. of Health NO TY 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I at Part II af item 18.) 200 ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20d INJURY OCCURRED (City or town) (State) 20c. TIME OF INJURY Month, Day, Year Haur a m. 20e. PLACE OF INJURY (Home, form, (County) factory, street, affice bldg., etc.) Nat While at work at wark FUNERAL DIRECTOR: After , 19 , to Nov. 28, 1967, that (1) (364 last 21 I certify that (1) (this he saided oftended the deceased from 1960 O HOSPITAL OR ATTEND Page 4 may be retained filed with the saw the deceased alive on Nov. 28. 19.67, and that death accurred at_ M, from causes and on the date stated above 22a SIGNATURE 22b DATE SIGNED M.D. DIRECTOR PHYS 22d. ADDRESS 22c. PHYSICIAN'S NAME (Type) Robert R. Hahn, M.D. Box-73. Severna Park. Md. 236 DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) 23a BLRIAL, CREMATION (State) REMOVAL (Specify) 12/4/67 Druid Ridge Cem. saltimore, na. 9 ADDRESS 2So REC'D BY REGISTRAR F. D. - Blol Edmondson ave. VR A15 (4) 25M 1/67



301 W. PRESTON STREET, BALTIMORE 1, MARYLAND OF DEATH I. PLACE OF DEATH USUAL RESIDENCE (Where decresed lived, if natifullon, Residence before edmission) a. COUNTY a. STATE **b. COUNTY** Anne Tundel MARVLAND 1-arvland anne arumiel b. CITY OR TOWN (if outside corporate limits. c. LENGTH OF STAY IN 15 c. CITY OR TOWN (If outside corporets fimits, write RURAL and give nearest town) write RURAL and give nearest town) alen Purnie pevern d NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) d STREET ADDRESS IS RESIDENCE ON A FARM? ON Sox 60 a nt 3. NAME OF 4. DATE Middle Month DECERSED OF (Type or print) DEATH ã within REYR-OLDS 19 6 IVOV. amd cor carbon 6. COLOR OR RACE 8. DATE OF BIRTH AGE (In years | IF UNDER & YEAR IF UNDER 24 HRS. 7. MARRIED NEVER MARRIED lest birthday) Months male WIDOWED [DIVORCED remove 10a. USUAL OCCUPATION (Giva kind of work 10b. KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (County & State, or foreign country) 12. CITIZEN OF WHAT COUNTRY don's during most of working life, even if retired) retired policeman City Dept. Baltimore, riaryland 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME ≘ attending arthur Reynolds latilda Stilling 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 1 17. INFORMANT Address (Yes, no, or unkown) | (il yes give wer or dates of service) signad by the merbert Revnolds-son physician. 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). INTERVAL BETWEEN ONSET AND PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) F 16 W 1 DUE TO attending Conditions, if any, which geve rise to immediate cause. **DUE TO** (a), stating the underlying causa fast. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(s) 19. WAS AUTOPSY CERTIFICATION 2 G PERFORMED? US@ prior YES NO 20a ACCIDENT WAS UNDERLYING 20b. DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Part I or Pert II of Itam 18.) OR CONTRIBUTING | CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) MEDICAL 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED | 20a PLACE OF INJURY (Homa, farm, 1 20f. (City or town) (County) (Steta) factory, street, office bldg., etc.) While Not While ŏ Hour a.m. at work at work p.m. attended the deceased_from... G-6M, from the causes and on the date stated above saw the deceased alive I and that death occurred at 22a SIGNATURE DATE ATTENDING S. GNED PHYS. DIRECTOR PHYS. ath. Page 4
FUNERAL M.D. page with 22d. ADDRESS 22c. PHYSICIAN'S filed v 23a, BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City, town or county) (Slate) REMOVAL (Spacify) OF New Cathedral Ceneterv will i 24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE **VR A15** annapolis...d. 20M



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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 74860 CERTIFICATE OF DEATH det 1 The law requires that the death certificate be executed within 24 haurs after death physician and complètely filled in by the funeral, en please remave carbat papers. Pages Vond 2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) PLACE OF DEATH o. STATE b. COUNTY n COUNTY MARY! AND Marvland Anne Arundel Anne Arundel b. CITY OR TOWN (If autside corporate mits, write RURAL and give nearest tawn) c CITY OR TOWN (If gutside carparate limits, write RURAL and a ve nearest town) CLENGTH OF STAY IN 1b. Riviera Beach Riviera Reach d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e IS RES DENCE ON A FARM? #265 Harlem Rd. NO S # 265 Harlam Rd. 3 NAME OF 4 DATE DECEASED OF DEATH November 19 67 RAYMONO RITTER (Type or print) RAIPH IF ... NDER 1 YEAR IF UNDER 24 HRS S SEX DATE OF BIRTH 9 AGE (In years 6. COLOR OR RACE 7. MARRIED NEVER MARRIED last_b rthday) Months Davs April 19,1905 White WIDOWED DIVORCED Male NDUSTRY STACK LOUSE

A C. & F. COAL 11, BIRTHPLACE (Caunty & State, or foreign country) 12 CIT ZEN OF WHAT Do USUAL OCC., PATION (Give kind of work done COUNTRY? during most of working the even if retired)
Welder & Miner CShickshinny, Penna. the attending physic nsit permit. Then ple 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME Mary Geist William S. Ritter WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17 INFORMANT Address (Yes, na, ar unknown) (If yes give war ar dates of service) 181-03-6215 Mrs. William Kelly (Daughter) Same as INTERVAL BETWEEN CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c)) signed by the burial-transit p ONSET AND DEATH PART I. DEATH WAS CAUSED BYIMMEDIATE CAUSE (0) MASSIVE PNEUMOTHORAX (6) CHRONIC OBSTRUCTIVE PUL. EMPHY SEMA UNKOWN Conditions, if any, which gove 3 rise to immediate couse (a), far use as the t Health priar ta b stating the underlying couse TO FUNERAL DIRECTOR: After this certificate has been WPNEUMOCONIOSIS (COAL MINERS) UNKOWN PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) WAS AUTOPS PERFORMED? MED CAL CERTIFICATION BRONCHITIS DUE TO ANTHRACOSIS YES -NO 🔀 ā 20g ACCIDENT WAS UNDERLYING □ 205. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Port II of item 18.) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER (Stote) 20d INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, (City or town) (County) TIME OF INJURY Manth, Doy, Year factory, street, affice bldg., etc.) Not While at work at wark 21. I certify that (I) (this hospital) attended the deceased from APRIL , 1967, that (I) (we) last , 1966 , to NOV director, page 3 should should be filed with the 1967, and that death accurred at 8207 M, from causes and on the date stated above. saw the deceased alive an NOV 3 22a. SIGNATURE 22b. DATE SIGNED M.D. DIRECTOR 22d. ADDRESS 22c. PHYSICIAN'S PASADENA MD 21122 34 MOUNTAIN RD JR., M. D. NAME (Type) 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) (County) 23a. BUR AL, CREMATION REMOVAL (Specify) Nov. 8.1967 Pine Hill Cemetary Shickshinny, Penna. Buria! 2So. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR Elianias VR A15 (4) 20 M 1/66 Glen Burnie, Md. DATE NOV 7 Funeral Home Sinoleton

MARYIAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH 14868 1. PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. COUNTY a. STATE **b** COUNTY Anne Arundel Anne Arundel MARYLAND Maryland The law requires that the death certificate be executed within 24 haurs after b. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 c CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) Annapol is Annapolis d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e S RESIDENCE ON A FARM? 10 Constitution Ave. NO X Anne Arundel General Hospital and completely furnemove carban First DATE Dav DECEASED (Type or print) ROSAT DEATH November Joseph Anthony 9 AGE (In years last pirthday) S SEX 6 COLOR OR RACE IF JNDER 1 YEAR B. DATE OF BIRTH IF LINDER 24 HRS 7. MARRIED NEVER MARRIED Months Days WIDOWED DIVORCED September 27,1901 White Male 10o USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or fareign cauntry) 12 CITIZEN OF WHAT during most of working life, even if retired) INDUSTRY COUNTRY? Virginia U. S. 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME crematian, or removal, WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO 17 INFORMANT (Yes, no ar unknown) (If yes give wor at dates of service 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) NTERVAL BETWEEN by the transit PART I. DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (0) Mayour Constral and ail DUE TO Conditions, if any, which gave nse to immediate cause (a), DUE TO stating the underlying cause to Hospital or ATTENDING PHYSICIAN: The low re Page 4 may be retained by the haspital ar attending 19 WAS AUTOPSY PERFORMED? PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(g) ar use NO TO 20a ACCIDENT WAS UNDERLYING [20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part II of item 1B) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) F 20c TIME OF INJURY Month, Day, Year 20d IN. JRY OCCURRED 20e PLACE OF INJURY (Home, form, (City or town) (County) (State) Haur o.m. factory, street, office bldg, etc.) While ___ Nat While at work at work 21 I certify that (1) (this haspital) attended the deceased from \(\sqrt{\curs}\) , 1963, ta West. , 19 67 that (1) (we) last saw the decessed alive an Navall 1967, and that death accurred at 1968 M, from causes and on the date stated above. 22a SIGNATURE 22b. DATE SIGNED M D DIRECTOR PHYS 22c. PHYSICIAN'S 22d ADDRESS O FUNERAL NAME (Type) J ohn Hedeman 1407 Forest Drive, Annapolis, Md. M. D. 230 BURIAL CREMATION 23b. DATE THEREOF 25b



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14.39 14862 CERTIFICATE OF DEATH the death certificate be executed within 24 haurs after death 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) the funeral 1. PLACE OF DEATH o. COUNTY o STATE : COUNTY MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b CITY OR TOWN (If autside carparate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 filled in IS RESIDENCE d NAME OF HOSPITAL/OR INSTITUTION (If not sp-hospita, give street/pddress) d STREET ADDRESS ON A FARM? NO DE YES and in any event, with DATE NAME OF First Lost Month Year carban campletely Type or print) OF DEATH 19 IF UNDER 24 HRS COLOR OR RACE 7 MARRIED NEVER MARRIED DATE OF BIRTH AGE (In years remove lost birthday) Manths Days Hours WIDOWED pup 10b KIND OF BUSINESS OR 12 CIT ZEN OF WHAT 11/BIRTHPLACE (County & State, or foreign country) 10o. USUAL OCCUPATION (Give kind of work-done during most of working to even if retired physicían a nen please INDUSTRY-13 FATHER S-NAME 14. MOTHER'S MAIDEN NAME buriar, crematian, ar remayal, attending phys IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO INFORMANI permit. (Yes, not or unknown) (If yes give war or dozes of service) INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter on y one couse per line PART I, DEATH WAS CAUSED BY signed by the burnal-transit (ONSET AND DEATH The law requires that IMMEDIATE CAUSE (o' Page 4 may be retained by the hospital or attending physician. DUE TO Conditions, if any, which gave rise to immediate cause (a). DUE TO stating the underlying couse detached for use as the te Dept of Health pnor to has been last. WAS AUTOPS)
PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN THE PART I(0) CATION NO certificate PHYSICIAN: 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) 200 ACCIDENT WAS UNDERLYING ... OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER director, page 3 shauld be detache shauld be filed with the State Dept 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, farm, (City or town) (County) (State) 20c TIME OF INJURY Month, Doy, Year FUNERAL DIRECTOR: After this Haur 'a m. factory, street, affice bldq., etc.) While Nat While OR ATTENDING ot work of work , 19___, that (1) (we) fast 21. I certify that (1) (this haspital) attended the deceased from 11-PM. fram causes and an the date stated above. saw the deceased alive an and that death accurred at 12 226 DATE SIGNED 22a. SIGNATUR DIRECTOR ADDRES 22c PHYSICIAN'S O HOSPITAL NAME (Type) (State) 23d. LOCATION (City or Town) 23a BUR AL, CREMATION DATE THEREO 230 (County REMOVAL (Specify) BUTTAL 9 ADDRESS 25a REC'D BY REGISTRAR 2Sb REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR VR A15 (4) 25M 1/67 196

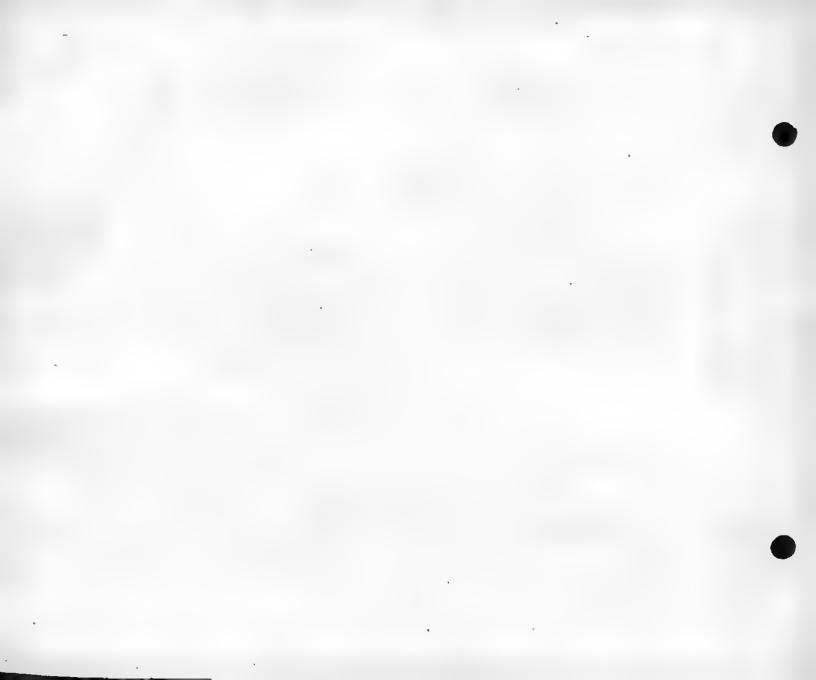


MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14863 CERTIFICATE OF DEATH death. requires that the death certificate be executed within 24 haurs after death l and 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) PLACE OF DEATH o. COUNTY a. STATE b. COUNTY ANNE ARUNDEL MARYLAND PRINCE GEORGES MARYLAND e f C LENGTH OF STAY IN 16 c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b CITY OR TOWN (If outside corporate I mits, write RURAL and give nearest town) by the LAUREL FT GEO G MEADE hr 52 min d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d STREET ADDRESS e. IS RES DENCE ON A FARM? 204 6th STREET and campletely filled YES NO K KIMBROUGH ARMY HOSPITAL carban 3 NAME OF 4 DATE F.rst Middle Lost Month Doy Year DECEASED OF INFANT BOY SCOTT VOVEMBER Type or print DEATH NEVER MARRIED X IF UNDER 1 YEAR IF UNDER 24 HRS S SEX 6. COLOR OR RACE B DATE OF BIRTH AGE (In years 7 MARRIED remove last birthdoy) Months Dovs Hours NOV 13.1967 WHITTE and in any MALE WIDOWED DIVORCED 10o USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR 11 BIRTHPLACE (County & State, or foreign country) 12 CIT ZEN OF WHAT please during most of warking life, even if retired) INDUSTRY COUNTRY? Anne Arundel, Md TISA 14. MOTHER'S MAIDEN NAME 13 FATHER'S NAME removal, en. LEROY F. SCOTT, JR. REGINA C. SUSSMETER attending permit. The father) WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO 17. INFORMANT Address (Yes, no, or unknown) (If yes give wor or dates of service) Ö Leroy F. Scott, Jr. (same as Item #2) bund, crematian, INTERVAL RETWEEN 18. CAUSE OF DEATH (Enter only one couse per fine for (o), (b) and (c)) signed by the burial-transit p ONSET AND DEATH PART I. DEATH WAS CAUSED BY. PULMONARY ATELECTASTS IMMEDIATE CAUSE (o) 160 01 2 DUE TO PREMATURITY Conditions, if any, which gave rise to immediate couse (a). DUE TO stoting the underlying couse O FUNERAL DIRECTOR: After this certificate has been detached for use as the e Dept. of Health prior ta last. 19. WAS AUTOPSY PERFORMED? PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) MEDICAL CERTIFICATION NO YES Page 4 may be retained by the haspital ar 20b, DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18) 200. ACCIDENT WAS UNDERLYING [OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) be detached State Dept. of 20d INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, (City or town) (County) (Stote) 20c. TIME OF INJURY Month, Doy, Year Haur o.m. foctory, street, office bldg., etc.) Not While ot work 13 Nov , 1967, that (1 (we) last 21. I certify that (1) (this haspital) attended the deceased fram 13 Nov 19.67 ta 1967, and that death accurred ab: OOp M, from couses and on the date stated abave. saw the deceased alive an_ 22o. SIGNATURE 22b. DATE SIGNED 13 NOV 67 DIRECTOR PHYS. M.D. 22c. PHYSICIAN'S 22d. ADDRESS director, pure NAME (Type) ROBERT E CULLEN JA KIMBROUGH ARMY HOSP FT GEO G MEADE MI 23c NAME OF CEMETERY OR CREMATORY 23o. BURIAL, CREMATION 23b DATE THEREOF 23d. LOCATION (City or Town) (County) (Stote) BEMOVAL (Specify) 25b REGISTRAR'S SIGNATURE FUNERAL DIRECTOR 2So REC'D BY REGISTRAR Mlones VR A15 (4) 1967 20 M 1/66 DATENINV





MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14865 14872 CERTIFICATE OF DEATH requires that the deoth certificate be executed within 24 hours ofter death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) o. STATE Maryland a COUNTY b. COUNTY Anhe Atundel Anne Arundel **MARYLAND** b CITY OR TOWN (If autside carporate limits. c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLENGTH OF STAY IN 16 write RURA, and give nearest town) Owings the attending physican and completely filled means is permit. Then please remove carbon agones. Revell Highway Rural d NAME OF HOSPITAL OR INSTITUTION (fination haspital, give street address) IS RESIDENCE ON A FARM? d. STREET ADDRESS YES X NO T Bay Manor Nursing Home 3. NAME OF Middle First Lost 4. DATE Month Doy Year DECEASED 0F 1967 27 MINUL REBECCA SHIPPLET November (Type or print DEATH F UNDER 1 YEAR S SEX 9 AGE (In years IF UNDER 24 HRS. 6 COLOR OR RACE 7. MARRIED NEVER MARRIED DATE OF BIRTH 66 birthday) Manths Davs March 4.1901 ony WIDOWED DIVORCED White Female 100 USUA. OCCLEAT ON (Give kind of work dane during most of working life, even if retired) 106 KIND OF BUSINESS OR 31 BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT COUNTRY? INDUSTRY Calvert Co., Maryland Housewife 13 FATHER'S NAME 14 MOTHER'S MAIDEN NAME Joshua L. Sears Mary K. Taylor
17 INFORMANT IS WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes a ve war or dates of service 5 Owings, Maryland Woodrow Shifflet No INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c),) buriol-transit p PART I DEATH WAS CAUSED BY ONSET AND DEATH IMMEDIATE CAUSE (a) signed by DHE TO Conditions, if ony, which gove rise to immediate couse (o). DHE TO stating the underlying cause os the the hospital or ottending O FUNERAL DIRECTOR: After this certificate has been last. 19 WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) PERFORMED? for use J NO O 20g ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH 205, DESCRIBE HOW INJURY OCCURRED, (Enter nature of injury in Port I or Port II of item 18.) detached (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INJURY OCCURRED 20e PLACE OF INJURY (Hame, farm, (City or town) (County) (State) 20c TIME OF INJURY Month, Day, Year Haur o.m factory, street, office oldg., etc.) Not While at work at wark TO HOSPITAL OR ATTENDINI Page 4 may be retained by 21. I certify that (1) (this bose tell) attended the deceased fram 2/13 1967, to 1/127, 1967, that (1) (wa) last 13 19 67, and that death occurred at 1:20 P.M. from couses and on the date stated above sow the deceased alive on 220 SIGNATHER 22b. DATE SIGNED ATTENDING DIRECTOR M.D PHYS PHYS. director, page should be filed 22d ADDRESS PHYSICIAN'S NAME (Type) 16 marke 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Fown) BURIAL, CREMATION 23b DATE THEREOF (County) (State) Burial (Specify) Dunkirk Md-Calvert Nov.30.1967 So. Memorial Gardens 25b. REGISTRAR'S SIGNATURE FUNERAL DIRECTOR 25a, REC'D BY REGISTRAR Veryland, Maryland MEC



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 OF DEATH 14573 The law requires that the death certificate be executed within 24 hours ofter death 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) 1. PLACE OF DEATH n. COUNTY a. STATE b. COUNTY Anne Arundel Maryland Arundel Anne MARYLAND b CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) c CITY OR TOWN (If guits de carparate limits, write RJRAL and give nearest town) c LENGTH OF STAY IN 16 Annapolis Life Annapolis d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address) d. STREET ADDRESS IS RESIDENCE ON A FARM? popezs. 135 Eastern Ave.. NO XX Anne Arundel General Hospital YES losSr . 3 NAME OF Middle 4 DATE Year DECEASED (Type or print) Smith. Jy. Charles Edward 19 67 November DEATH IF UNDER 1 YEAR IF UNDER 24 HRS S. SEX 6 COLOR OR RACE XX NEVER MARRIED B DATE OF BIRTH 9 AGE (In years 7. MARRIED b rthday) Manths Nov. 1. 1900 Male MIDOWED DIVORCED Negro 10b KIND OF BUSINESS OR 11. BIRTHPLACE (County & State or foreign country) 12 CITIZEN OF WHAT 10a USUAL OCCUPATION (Give kind of work done COUNTRY? during most of working life eyes the tired S. Naval INRUSIS demy Annapolts physicion Maryland 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME buriol, cremotion, or removal, offending phys Mary E. Brown Smith Frank Annapolis, ka. 15 WASDECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (if yes give war ar dates of service) 16 SOCIAL SECURITY NO. 17 INFORMANT Charlette J. Smith-135 Eastern Ave. 218-26-5090 1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY: INTERVAL BETWEEN buriol-transit IMMEDIATE CAUSE (a). DUE TO Conditions, if ony, which gave rise to immediate cause (a), DUE TO stoting the underlying couse 19 WAS AUTOPSY PERFORMED? YES XX NO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) be detached for use State Dept. of Health 20g ACCIDENT WAS UNDERLYING [20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 1B) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER 20e PLACE OF INJURY (Hame, farm (City or town) (County) (State) 20c TIME OF INJURY Manth, Doy, Year Haur a.m. 20d INJURY OCCURRED Nat While factory, street, affice bldg., etc.) FUNERAL DIRECTOR: After 1964, ta Nov. 2, , 1967 that (1) (as) last at ______ M, fram causes and an the date stated above. 21. I certify that (I) (this handle) attended the deceased fram_ Poge 4 moy be retoined saw the deceased alive an Nov. 2. 19.67, and that death accurred at 220. SIGNATURE 22b. DATE SIGNED STAFF PHYS. ATTENDING DIRECTOR 22d ADDRESS PHYSICIAN? O HOSPITAL director, po should be f 16 Murray Ave., Annapolis, Md. NAME (Type) ochman 23d LOCATION (City or Town)
Anna polis, Md. 23a BUR AL, CREMATION, 23b DATE THEREOF NAME OF CEMETERY OR CREMATORY (County) (State) Bu PEMOYAta (Specify) Nov. 6-67 St Annes NOV 9 1967 ADDRESS 24 FUNERAL DIRECTOR VR A15 (4) NOV 9 C.E. Hicks 111 Annapolis, Md.

MARYLAND STATE DEPARTMENT OF HEALTH





MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14875

RTIFICATE OF DEAT

		CERTIFICATE	UF DEATH							
PLACE OF DEATH			2 USUAL RESIDENCE	Where deceased ved, if institution Re	s dence before admission)					
a. COUNTY	Anne Arundel	MARYLAND	o. STATE Maryland b. COUNTY Ar a Armade							
write RURAL or	(If outside carparate imits, ed give nearest tawn)	c LENGTH OF STAY IN 16	c CITY OR TOWN (if autside corporate limits, write RURAL and give nearest town)							
	TAL OR INSTITUTION (If not in	haspital, give street address)	Glen urnie d. street Address clo Cakdale Circle de 15 residence on A FARM? Yes □ No [
	Oakdale Circ									
3 NAME OF DECEASED (Type or print)	First Cathe	Middle	Lost	4 DATE Month OF OF OV.	Day Year 3 19 57					
S SEX	6. COLOR OR RACE 7	MARRIED [2] NEVER MARRIED	8. DATE OF BIRTH	9 AGE (In years IF JI	NDER 1 YEAR IF UNDER 24 HRS					
Temala e	Thite W	IDOWED DIVORCED	12 18 1910	last birthday) Man	ths Days Haurs Min.					
during mast af warking	N (Give kind of work done life, even if retired) -Retired	106 KIND OF BUSINESS OR INDUSTRY Schools	11 BIRTHPLACE (County Balto.	, , , , , , , , , , , , , , , , , , , ,	2. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME			14. MOTHER'S MAIDEN							
T.C	mis Schmidt		.110	na deimel						
	ER IN U.S. ARMED FORCES? (If yes give war ar dates af sen		INFORMANT	Address						
(Yes, ra, or unknown)	(If yes give war ar dates at serv	119.05.2076 IT	. Panl D. S	tenffer	Sa: e					
18. CAUSE OF D PART I. DEA	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) General carcinomatosis									
Canditians, if and ise to immedia stating the und	DUE TO y, which gave (b) (b) DUE TO	Carcinoma of left	breast		3½ years					
last.										
PART II OTHER S	PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
OR CONTRIBUTING	AS UNDERLYING GCAUSE OF DEATH MEDICAL EXAMINER) no.	206 DESCRIBE HOW INJURY OCCURRED	(Enter nature of injury in	Part I or Part II of item 18)	YES NO P					
	JURY Manth, Day, Year .m. 19		CF OF INJURY (Hame, for tary, street, affice bldg., etc		(Caunty) (State)					
21 cert	ify that (I) (this hospital leceased alive an NOV.	Lattended the deceased fram_ 9 19 67, and the	May 7,	19 57, to Novem 1 3	319 <mark>67</mark> , that (I) (we) loan the date stated abov					
22a SIGNATURE	120	ft / M.	1 111 0	MED STAFF DIRECTOR PHYS. 222	DATE SIGNED 11-14-67					
22c. PHYSICIAN' NAME (Type		J, M. D.	22d. ADDRESS	E. Randall St.B	altimoreMd2123					
23a BURIAL, CREMATI REMOVAL (Specif		230 NAME OF CEMETERY OR		23d. LOCATION (City or Town) Dorsey. 16d.	(Caunty) (State)					
24 FUNERAL DIRECT	OR	ADDRESS	25a. RSC.		IRS SIGNATURE					
	. c Jully	130 %. Fort 4-V	e DATE	OA TO IOOI						

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely fitted in by the funeral director, page 3 should be detached for use as the bunal-transit permit. Then please remove carban pagers, Pages 1 and 2-should be filed with the State Dept. of Health priar to burial, crematian, or remayal, and in any event, within 72 hours after death. **10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours ofter death Page 4 may be retained by the haspita ar attending physician.

VR A15 4

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 30) W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14869 14876 CERTIFICATE OF DEATH and, 2 earth. requires that the death certificate be executed within 24 hours after death 2 USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) the funeral PLACE OF DEATH o. COUNTY o. STATE b. COUNTY Maryland Anne Arundel Anne Arundel MARYLAND c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b CITY OR TOWN (If outside corporate limits, c LENGTH OF STAY IN 16 write RURAL and give nearest town) 2 DAYS Arnold Annapolis remove carban papers. in any event, within 72 ha d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, a ve street oddress) A STREET ADDRESS e IS RES DENC ON A FARM? Box 126 YES NO IX Anne Arundel General Hospital 3 NAME OF Last 4 DATE Day DECEASED SWITZER DEATH November (Type or pnnt) William Henry IF UNDER I YEAR 9 AGE (In years IF UNDER 24 HRS S. SEX 6. COLOR OR RACE 7 MARRIED 8 DATE OF BIRTH NEVER MARRIED ost b "hdoy) Months Days WIDOWED DIVORCED December 12,1896 Male White 10o USUAL OCCUPATION (Give kind of work done 12. CITIZEN OF WHAT 10h. KIND OF BUSINESS OR 11. BIRTHPLACE (County & Stote, or foreign country) during most of working life even if retired)
RETIRED MACHINIST B. CO. RATIROAD COUNTRY ? Maryland U. S. 14 MOTHER'S MAIDEN NAME 13. FATHER'S NAME ar remaval, SAMUEL SWITZER MARY JOSEPHINE LAWRENCE Address 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INFORMANT (Yes, np. ar unknown) (If yes give wor ar dates of service) MR. JEAN W. SHOWE. BOX 126 .ARNOLD. MD INTERVAL BETWEEN 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c), transit 200 SET AND DEATH PART I. DEATH WAS CAUSED BY Hepatic coma IMMEDIATE CAUSE (o). **DUE TO** signed burial-tr Gastrointestinal hemorrhage 2 days Conditions, if any which gave nse to immediate couse (o), DUE TO stating the underlying couse Carcinomatosis (hepatic) vears PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN N PART 1(o) 19 WAS AUTOPS PERFORMED? cirrhosis, arteriosclerotic cardiovascular disease NO Suspected primary carcinaon of panereas

20b. DESCRIBE HOW INJURY OCCURRED [Enter noture of njury in Part I or Port I of them 18] ATTENDING PHYSICIAN: OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c TIME OF INJURY Month, Doy, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form (City or town) (County) (elo12) Hour o.m. foctory, street, office bldg., etc.) Not While TO FUNERAL DIRECTOR: After 1967, that (I) (we) last 21. I certify that (1) (this haspital) attended the deceased fram June 20 1967 taNov 24 be retained director, page 3 should should be filed with the saw the deceased alive an Nov 24 1967 and that death accurred at fram causes and an the date stated above. 22b. DATE SIGNED 22o. SIGNATURE DIRECTOR PHYS. Nov 24, 1967 22d, ADDRESS 16 Murray Avenue 22c PHYSICIAN NAME (Type) Charles W. Kinzer, M. D. Annapolis, Maryland 21401 230 BUR AL, CREMATION 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d. LOCATION (City or Town) (County) (Stofe) 11/27/67 ROSE HILL CEMETERY HAGERSTOWN, WASH, CO. MD 2Sb REGISTRAR S SIGNATURE 24 FUNERAL DIRECTOR 25o. REC D BY REGISTRAR VR A15 (4) 25M 1/67 CHARLES M. ROUZER, HAGERSTOWN, MARYLAND



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14377 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1 PLACE OF DEATH 2 USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) o COUNTY o. STATE b COUNTY delay is and 3 to M3 Page MARYLAND b CITY OR TOWN I floutside corporate limits c LENGTH OF STAY N Ib c CITY OR TOWN (If guts de corparate limits, write RURAL and give nearest town) write RURA, and give nearest town.

GIEN BUR ALL

d NAME OF HOSPITA, OR INSTITUTION (I not in hospita, give street oddress) BALLIAGUE - 26-rul d STREET ADDRESS 140-9renland Bauch Rd d STREET ADDRESS alang with form D.O. N-NORTH. ARUNDIEL - HOSP, InL 3 NAME OF DECEASED OF DEATH 19 67 S SEX NEVER MARRIED 9 AGE (In years JE UNDER 1 YEAR lost birthday) 8-2-17 WIDOWED | DIVORCED | event within 72 haurs after death IDo USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) 10b KIND OF BUSINESS OR 11 BIRTHPLACE (State or fore an country) 12 CITIZEN OF WHAT INDUSTRY COUNTRY? Office Manager Balto, Md, 14 MOTHERS MAIDEN NAME USA Construction Ind. 13. FATHER'S NAME Laura Pelmanowski Frank Szmajda 17. INFORMANT IS. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO Address 21226 [Yes, no, ar unknown] [[If yes give war or dates of service] 220-14-9058 Mrs Frank M. Szmajda 140 Greenland Beach Rd 18. CAUSE OF DEATH (Enter only one couse per line-for (o), (b), and (c).) INTERVAL BETWEEN ONSET AND DEATH PART I DEATH WAS CAUSED BY: in due threepe IMMEDIATE CAUSE (a) _ DUE TO Conditions, if ony, which gove) rise to immediate couse (a), DUF TO stoting the underlying couse PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN N PART 0. 19 WAS AUTOPS PERFOR MED? NO DR 2Do. EXTERNAL CAUSE WAS 20b DESCRIBE HOW NURY OCCURRED (Enter noture of neury in Port I or Part II of tem 18.) PRIMARY I or CONTRIBUTING I CAUSE OF DEATH 2Dc TIME OF INJURY Month, Doy, Year 2Dd NJURY OCCURRED 2De PLACE OF NJURY Hame form 20f (City or town) (Stote) foctory, street office bldg, etc.) While of work of work 21 I certify that I taak charge of the remains described above held an Autopsy , nspection , Inquiry , and in my apinion death resulted from Natural causes , Accident , Suicide , Hamicide , Undetermined manner CHIEF MEDICAL EXAMINER ACTUAL 22 DATE SIGNED ASSISTANT MEDICAL EXAM NER SIGNATURE DEPUTY MEDICAL EXAMINER Aduress (Street Jily town or county) 23c NAME OF CEMETERY OR CREMATORY 23, 10.ATON ity Town) 230 8 RIAL (REMATION 0 REMOVAL Space (y) Balto., Md. Druid Ridge Cem 11-13-1967 250 RELD BY REGISTRAR 25b REGISTRAR'S SIGNATURE ADDRESS 24 FUNERAL DIRECTOR VR ATSME Ocharles Judge Wm. Cook-Brooks, Inc. 1217 St. Paul St. Balto. DATNOV 13



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14578 CERTIFICATE OF DEATH 2 USUAL RESIDENCE (Where deceased lived, funstitution Residence before admission) PLACE OF DEATH o. COUNTY o. STATE b. COUNTY Maryland Anne Arundel Anne Arundel MARYLAND PHYSICIAN: The law requires that the death certificate be executed withi6-24-hours after c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b CITY OR TOWN (if outside corporate limits, ¿ LENGTH OF STAY IN 16 write RURAL and give nearest town) Annapolis Annapolis e. IS RES DENCE ON A FARM? d NAME OF HOSPITA. OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS Poplar St., 1413 Anne Arundel General Hospital NO XX burial, cremation, ar remayal, and in any event, within 3 NAME OF pay First Middle Last 4 DATE Month Dov Year campletely DECEASED TAYLOR November 19 67 Finna Helen DEATH (Type or print) COL F UNDER 1 YEAR F UNDER 24 HRS 9 AGE (In years S SEX 6 COLOR OR RACE 7. MARRIED NEVER MARRIED B. DATE OF BIRTLE remove log pirthday) Doys Hours Jan. 25, 1886 Female White WIDOWED XIX DIVORCED 11. BIRTHPLACE (County & State, or foreign country) 12 CITIZEN OF WHAT 100 USUAL OCCUPATION (Give kind of work done 10b KIND OF BUSINESS OR INDUSTRY Own Home Elizabeth, New Jersev 14. MOTHER'S MAIDEN NAME 13. FATHER'S NAME attending phy: p≡rm t Then f Wilhelmina Kramer Martin Kramer Address 413 Poplar St IS WAS DECEASED EVER IN U.S. ARMED FORCES? 17 INFORMANT 16. SOCIAL SECURITY NO (Yes no, or unknown) (If yes give wor or dotes of service) 16-24-6313 Mrs. Robert Beall Sr. parm Annapolis, Md. 18 CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c) PART 1 DEATH WAS CAUSED BYIMMEDIATE CAUSE (o) Congastical (o) INTERVAL BETWEEN signed by the burial-transit p ONSET AND DEATH Herry O HOSPITAL OR ATTENDING PHYSICIAN: The law requires the Page 4 may be retained by the hospital or attending physician. DUE TO 4 intelerment last Conditions, if any, which gove) rise to immediate couse (a), DUE TO stoting the underlying couse the with the State Dept, af Health prior to So 19 WAS AUTOPSY PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM.NAL DISEASE CONDITION GIVEN IN PART 1(o) PERFORMED? use NO certificate 200 ACCIDENT WAS UNDERLYING 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port I or Port II of item 18) OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER MEDICAL 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form 20f (City or town) (County) (Stote) 20c TIME OF INJURY Month, Doy Year O FUNERAL DIRECTOR: After this Not While Hour em. foctory, street, office bldg , etc.) at work , 1966, to Nov. L., 1967, that (1) (We) last 21 | certify that (1) (\$100000001) attended the deceased from August sow the deceased alive on Nov. 1. 19 67, and that death occurred at ____M, from causes and on the date stated above. 220 SIGNATURE 22b DATE SIGNED ATTENDING MED OIRECTOR MD 22d ADDRESS 22c. PHYSICIAN'S director, pa NAME (Type) 121 Cathedral St., Annapolis, Md. 23d. LOCATION (City or Town) 23c NAME OF CEMETERY OR EREMATORY (Stote) 23o. BURIAL, CREMATION. 23b DATE THEREOF Burial (Specify) Arnold Asbury Meth Ch Cem Md. S to REC D BY REGISTRAR 2Sb REGISTRAR 5 SIGNATURE 24 FUNERAL DIRECTOR VR A15 (4) 25M 1/67 Home Anna. Md. Milanelas Judge DATE OV

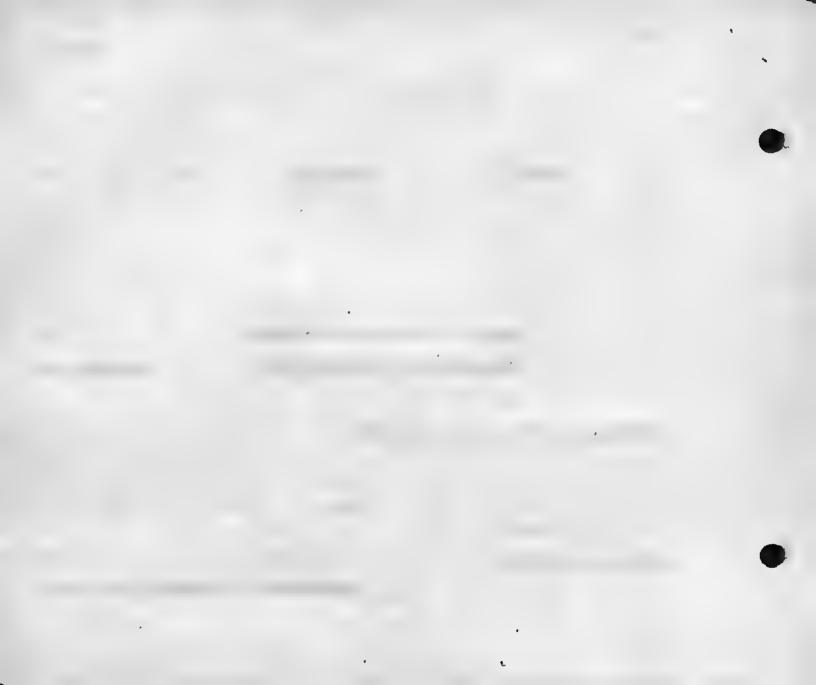


DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH I. PLACE OF DEATH 2. USUAL RESIDENCE [Where decessed ..ved, If institution: Residence before admission] a. COUNTY **b.** COUNTY Anne Arundel MARYLAND b, CITY OR TOWN (if outs de corporete limits, c, CITY OR TOWN (If ourside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 16 write RURAL and give nearest town] Pasadena d. NAME OF HUSYITAL OR INSTITUTION (if not in hosp: of a ve street address) d. STREET ADDRESS a. IS RES.DENCE ON A FARM? 3 Altooma Avenue AA General Hospital YES NO 3 3. NAME OF 4. DATE M ddle Month DECEASED WAGNER [Type or print] DEATH NOW 1967 6. COLOR OR RACE 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH 9. AGE (In yours IF UNDER 1 YEAR IF UNDER 24 HRS. last birthday) | Months | 24 Sept. 1887 WIDOWED T DIVORCED -Fc male TOB. USUAL OCCUPATION (Give kind of work 1 10b. KIND OF BUS NESS OR INDUSTRY, 11 BRTHPLACE (County & State, or fore gn country) 1 12. CITIZEN OF WHAT COUNTRY? done during most of working life, even if retired) Lousewife AA County, larylnd ISA Own Home 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME Stinchcomb 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (Yes, no, or unkown) (If yes give wer or dates of service) Mrs. Erma Roles, same as 2 IB. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (6) MASSIVE CEREBRAL HEMORRHAGE DUE TO W GENERALIZED ARTERIUSCLERUSIS Conditions, if any, which MORE THAN 104RS geve rise to Immediate cause DUE TO (a), stating the underlying PART IL OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a), 19. WAS AUTOPSY PERFORMED? PARTERIOSCLEROTIC HEART DISEASE NO 20a. ACCIDENT WAS UNDERLY NG CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW .NJURY OCCURED. (Enter nature of njury in Pert I or Pert I of tem 18] 20d, INJURY OCCURRED 20e, PLACE OF INJURY (Home, form, 20f. (City or town) 20c. TIME OF INJURY Month, Dey, Year (County) factory, street, office bldg., etc.) While Not While Hour am. et work et work 21. I certify that (i) (this hospital) attended the deceased from APRIL 19..., 1963, to NOV 10....., 1967., that (i) (we) last 22e SIGNATURE SIGNED DRECTOR MD PHYS. (William o 22d. ADDRESS LANKFORD, JR., M. D. 2934 MOUNTAIN RD PASADENA, MD filed v 230. BURIAL, CREMATION, 236. DATE THEREOF 230. NAME OF CEMETERY OR CREMATORY REMOVAL (Specify) Glen Hayen Lemorial Glen Jurnie, Maryland buria 13 Nov. 67 250, REC'D BY REGISTRAR | 256, REGISTRAR'S SIGNATURE 24 FUNERAL DIRECTOR'S SIGNATURE VR A15 (4) 15M 9/60 Funeral Home. Glen Burnie. 1d.

HOSPITAL Jeath, Page

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RYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 11.073 CERTIFICATE OF DEATH 24 haurs after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution Residence bergle admission) o COUNTY o STATE b COUNTY Anne Arundel MARYLAND Maryland
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b CITY OR TOWN (If outside corporate limits, c LENGTH OF STAY IN 16 write RURAL and give nearest town) 5 months Crownsville Raltimore d NAME OF HOSPITAL OR INSTITUTION (If not in haspita, give street address) filled in propers. d. STREET ADDRESS 9 IS RESIDENCE ON A FARM? Crownsville State Hospital YES NO F 3004 Larue Stree law requires that the death certificate be executed within NAME OF Middle Last 4. DATE Day ban Year DECEASED (Type of print) OF DEATH and in any event, Odessa Whitfield remove car S SEX IF JNDER 1 YEAR 6. COLOR OR RACE NEVER MARRIED 8 DATE OF BIRTH 9. AGE In years IF JNDER 24 HRS 7. MARRIED urthday) Manths WIDOWED DIVORCED Female Negro 12/19/05 gud 10a USUAL OCCUPATION (Give kind of work done during mast of working life, even if retired) 10b. KIND OF BUSINESS OR 11. BIRTHPLACE (County & State, or fareign country) 12 CITIZEN OF WHAT INDUSTRY COUNTRY? attending physician sermit. Then please North Carolina
14. MOTHER'S MAIDEN NAME none IIS A 13 FATHER'S NAME signed by the attending physi burial-transit permit. Then pl bur al, cremation, ar removal, Laura Dawson Richard King 15 WAS DECEASED EVER IN U.S. ARMED FORCES? 17. INFORMANT 16. SOCIAL SECURITY NO Address (Yes, na, ar unknown) (If yes give war or dates of service) unknown Hospital Records, Crownsville, Maryland no 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY INTERVAL BETWEEN ONSET AND DEATH Uremia IMMEDIATE CAUSE (a) TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires the Page 4 may be retained by the hospital ar attending physician. DUE TO Conditions, if any, which gove (b) Arteriosclerotic cardio-vascular disease rise ta immediate cause (a), DUE TO stoting the underlying couse priar tal last. 19 WAS AUTOPSY PERFORMED? has PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(g) Decubitus ulcers; Chronic Brain Syndrome NO certificate YES 20b DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Port II of item 181) 20a ACCIDENT WAS JNDERLYING [1] OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20d INSURY OCCURRED 20f (City or town) 20c FIME OF IN, JRY Month, Day, Year 20e PLACE OF INJURY (Hame, form, (County) (State) Not Whi e factory, street, affice bldg., etc.) 21. I certify that (1) (this haspital) attended the deceased from 6/8 19.67 to 11/6/ 19.67, that (I) (we) last director, page 3 shauld shauld be filed with the TO FUNERAL DIRECTOR: saw the deceased alive on 11/6/ 1967, and that death occurred at 8.15 M, from causes and on the date stated above. 220 SIGNATURE 22b DATE SIGNED 11/7/67 M.D DIRECTOR PHYS 22c PHYSICIAN S 22d. ADDRESS NAME (Type) Benedict. Crownsville State Hospital Maryland 23a BUR AL CREMATION 23b DATE THEREOI NAME OF CEMETERY OR CREMATORY 23d LOCATION (City or Town) REMOVAL (Specify) aver 2Sb REGISTRAR'S SIGNATURE FUNERAL DIRECTOR 256 REC D BY REGISTRAR VII A15 (4) 25M 1/67

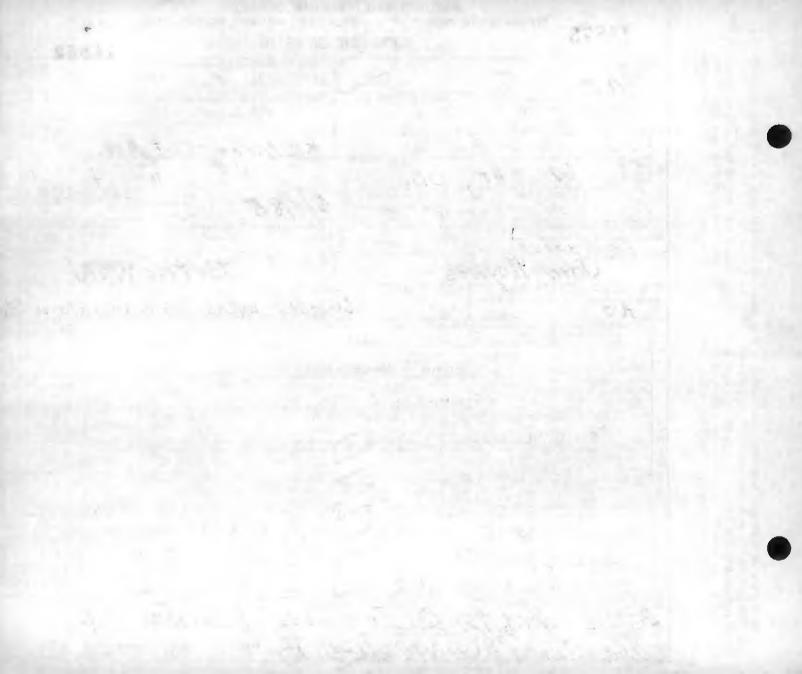


DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 14881 MEDICAL EXAMINER'S CERTIFICATE OF DEATH PLACE OF DEATH USUAL RESIDENCE (Where deceased I ved, if institution Residence before admission) o COUNTY o STATE b COUNTY MARYLAND delay b (ITY OR TOWN (If outside corporate imits r LENGTH OF STAY IN In c CITY OR TOWN (flouts de corporate limits, write RURAL and que nearest town) write RURAL and give negrest town) P.M.3. MUNIPOLIS FUNIAPOLISd. NAME OF HOSPITA, OR NSTITUTION (If not in hospital a ve street oddress) d STREET ADDRESS farm ON A FARM? 1.03 Ridge Adi in Item 18. Give Pages YES NO after death Office along with NAME OF M ddle 4 DATE Month Dav Year DECEASED OF WILSON 1967 NOV (Type or pnnt) DEATH S SEX IF UNDER 1 YEAR 6 COLOR OR RACE 8 DATE OF BRTH 9 AGE in years 7 MARRIED NEVER MARRIED b rthdoy) 7-11-48 event within 72 haurs after death WIDOWED 12 CITIZEN OF WHAT 10o USUA, OCCUPATION (Give kind of work done Do KIND OF BUSINESS OR 11 B RTHPLACE (State or foreign country) during most of working ife, even if retired) LINDUSTRY COUNTRY ? SOLF . EMPloyed 13. FATHER'S NAME in pencil a 16 SOCIAL SECURITY NO (Yes, no, or unknown) (If yes give wor or dates of service) ANISE FOLIS. F- VFLYN L. WILSON 18 CAUSE OF DEATH (Enter only one couse per ne for (o), (b), and (c) INTERVAL BETWEEN ONSET AND DEATH PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (o) certificate, writing the ward DUE TO Conditions, if ony, which gove rise to immediate couse (o). **DUE TO** stoting the underlying couse removal, PART II OTHER S GNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART TO 19 WAS AUTOPS PERFORMED? NO I YES. pe 200 EXTERNAL CAUSE WAS 20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Part 1 of Item 18) 3 should PRIMARY G or CONTRIBUTING G CAUSE OF DEATH. 20c T ME OF NJURY Month, Day, Year 2Dd INJURY OCCURRED 2De PLACE OF INJURY 'Home, form 20f (City or town (State) foctory, street office bldg etc.) Not While of work of work 21. I certify that I taak charge of the remains described above, held an Autopsy [7], Inspection [7], inquiry [7]. and in my opinian death resulted from Natural causes Accident . Su cide Hamicide | Undetermined manner CHIEF MEDICAL EXAMINER prior to ACTUAL 22 DATE SIGNED ASS STANT MED CAL EXAMINER SIGNATURE O DEPUTY DEPUTY MED CAL EXAM NER **EXAMINER'S** FO FUNER Heafth Address (Street city, town or county) NAME (Type 23c NAME OF CEMETERY OR TREMATORY 230 BURIAL CREMATION. 23d LOCATION City or Towns 250 RECD BY RECISTRAR VR A15ME 6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH within 24 hours after death PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. COUNTY b COUNTY MARYLAND b. CITY OR TOWN (If outside corporate limits, c. LENGTH OF STAY IN 16 c. CITY OR TOWN outside corporate limits, write RURAL and give nearest town) write RURAL and give nearest town la more Son would poperar Fin 72 h e IS RESIDENCE ON A FARM? d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS YES NO WIT 3. NAME OF Middle DATE remave carban DECEASED 196 (Type or print) DEATH The law requires that the death certificate be executed IF UNDER 1 YEAR IF UNDER 24 HRS S. SEX 6. COLOR OR RACE AGE (In years 7. MARRIED NEVER MARRIED last birthday) Months Dovs Hours D and in any WIDOWED DIVORCED FR YNYIS 10b. KIND OF BUSINESS OR 12. CITIZEN OF WHAT 10o. USUAL OCCUPATION (Give kind of work done 11. BIRTHPLACE (County & State, or foreign country) during most of working life, even if refired) ____ COUNTRY 2 INDUSTRY Kam avn 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAMI crematian, ar remava 15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURITY NO. (Yes, no, or unknown) (If yes give wor or dotes of service) 18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).) INTERVAL BETWEEN ONSET AND DEATH buriol-transit PART I. DEATH WAS CAUSED BY: Cardiac Failure IMMEDIATE CAUSE (o) signed by DUE TO burial, 1 Septic Embolisation Conditions, if ony, which gove rise to immediate couse (o), DUE TO SUNCOIO stating the underlying cause detached far use as the e Dept. af Health priar ta 19. WAS AUTOPSY PERFORMED? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(6) PIGS YES NO this certificate 20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) 20o. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Doy, Year 2Dd. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, (City or town) (County) (Stote) factory, street, office bldg., etc.) Not While at work of work 21. I certify that (1) (this haspital) attended the deceased from 11/3 , 1967, ta 11/4 1967, that (1) (we) last Page 4 may be retained saw the deceased alive an 11 121 1967, and that death accurred at 02304M, from causes and on the date stated above. FUNERAL DIRECTOR: 22o. SIGNATURE 22b. DATE SIGNED **ATTENDING** M.D. +1 [DIRECTOR PHYS PHYS 22d. ADDRESS 22c. PHYSICIAN'S HODKINS Tohns director, pur NAME (Type) Greene, MD Baltimbro Md 21205 23d LOCATION 230. BURIAL, CREMATION DATE THEREOF (Stote) EMOVAL Moeciful 9 25b. REGISTRAR'S SIGNATURE VR A15 (4) Ochonia



MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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2 dealine rate of the party	by the funaral Pages 1- and	13	1. PLACE OF DEATH ANNE ARUNDEL CO	OUNTY	MARYLAND	2. USUAL RESIDENCE a. STATE MARYL	Where deceased lived, if institution: Re b. COUNTY A	nsidence before odmission) NNE ARUNDEL				
S. ref	filled in by the papers. Pages hin 72 haurs aft	Lon.	b. CITY OR TOWN (If outside carp write RURAL and give nearest	town)	c length of stay in 16		utside corporate limits, write RURAL on	d give neorest town)				
	2 H 2 H 2	5	d. NAME OF HOSPITAL OR INSTITU	JTION (If not in hospital, g	ive street oddress)	d. STREET ADDRESS		e IS RESIDENCE ON A FARM?				
		52.0	KIMBROUGH ARMY HOSPITAL			509 SCHMIER RD, LAUREL MD. YES NO						
A STATE OF	ban	the	3. NAME OF DECEASED (Type or print)	First JOHN J	Middle OSEPH	Lost ZIDEK	4. DATE Month OF DEATH NOVEMBER	7 Poy Year 7 19 67				
· ·	implet ve car event,	11	S. SEX 6. COLOR OF	R RACE 7, MARRIED	X NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years IF U	NDER 1 YEAR IF UNDER 24 HRS				
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1	g physician and camplet Then please remove car maval, and in any event	2016	10o. USUAL OCCUPATION (Give kind of during most of working life, even if ret Construction La	work done 10b. Kill ired) NI borer Bi	ND OF BUSINESS OR DUSIRY LILding	11. BIRTHPLACE (County	& State, or foreign country)	2. CITIZEN OF WHAT COUNTRY?				
	al, o	\$	13. FATHER'S NAME			14. MOTHER'S MAIDEN						
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TO WAS DESCRIPTION OF THE PROPERTY AND THE COURT OF THE PROPERTY AND THE P							Address					
- 1	attendir permit.	1	NO	57	7-21-6992 M	ARY ZIDEK-W	IFE- 509 SCHMUER	RD. LAUREL MD				
4	an. by the att	Cx.	18. CAUSE OF DEATH (Enter of PART I. DEATH WAS CAUSE	nly ane cause per line for				INTERVAL BETWEEN				
1	y th		IMMEDIATE									
14	d by Cri	12	T201	DUE TO	RDTAL INFARTI							
	physician signed by the burial-transit	13	Conditions, if ony, which gave rise to immediate cause (a),	(b) <u>COF</u>	ONARY ARTERY	ARTERTOSCHL	EROIS					
	the the	23 /m	storing the underlying couse lost:	DUE TO								
1.0	has a lith pr	150	PART II. OTHER SIGNIFICANT CO	NDITIONS CONTRIBUTING TO	O DEATH BUT NOT RELATED TO	THE TERMINAL DISEASE CO	INDITION GIVEN IN PART 1(0)	19. WAS AUTOPSY PERFORMED? YES NO				
Diversion	first of Figure 1	ha	200. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF D	DEATH	CRIBE HOW INJURY OCCURRED.	(Enter nature of injury in	Port I or Port II al item 18.)					
	this etac Dep	A	20c. TIME OF INJURY Month, D Hour o.m.	Doy, Year 20d. IN While	Not While for	ACE OF INJURY (Hame, for tory, street, office bldg., etc		(County) (Stote)				
=	Steel by	7	21. I certify that (3) (this haspital) systemed the deceased from 7 NOV , 19 67 , taxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx									
ATTEMBILE	TOR: / should	20	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX									
1	be retaine DIRECTOR: 3e 3 shoul led with th	5	220. SIGNATURE	7/1	. /		22	b. DATE SIGNED				
90	be re 3 ed w	2n	Louise	1. succe	rice M.	D. PHYS.	DIRECTOR PHYS.	7 NOV 67				
	o page	Orong	22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS KIMBRO	UGH ARMY HOSPITAL							
O Uncentar	Page 4 may 10 FUNERAL director, pa	the	23a. BURIAL, CREMATION, 23b	D. DATE THEREOF	CPT MC 23c. NAME OF CEMETERY OR Oak Hill	CREMATORY .	23d. LOCATION (City or Town) Washington D.	(County) (State)				
-		247	24. FUNERAL DIRECTOR		ADDRESS	2So. REC	D BY REGISTRAR 256. REGISTRA	AB'S SIGNATURE				
	VR A15 (4) 25M 1/67	6 2	Francis Gasch'	s Sons Hya	ttsville, Md.	DATE	NOV 14 1961	liarles Judge				

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